

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5501		CITY OF BALTIMORE DEPARTMENT OF HEALTH		Registered No. 67 5501	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)		
			JOHN J KREPNER		
2. DATE AND HOUR OF DEATH			6/5/67 12:45 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
35 CHURCH HOME AND HOSPITAL			MARYLAND 2-01		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE		
			D. STREET ADDRESS (If rural, give location)		
			10 S. WASHINGTON ST.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
M	W	MARRIED	12/25/97	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
BARBER			MARYLAND		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
GEORGE KREPNER			MARGARET SELAMOR		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO NO			219-14-2291		31
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) MYOCARDIAL INFARCTION DAYS		
			(B) ARTERIOSCLEROTIC HEART DISEASE 4 YRS.		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6-2 1967 to 6-5 1967, that (I) (we) lost saw the deceased alive on 6-5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Rodolfo M. Lim M.D.				6-5-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Rodolfo M. Lim M.D.				Church Home & Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		6/8/67		SACRED HEART	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 7 1967		Robert E. Taylor		DIPPEL BRDS. INC 1700 E. LONG	

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5502</u>	
BIRTH NO. <u>67 5502</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH <u>6/5/67 11:04 P.M.</u>		
1. NAME OF DECEASED (Type or Print) <u>Sallie DeRossett</u>			A. STATE <u>Mo</u> B. COUNTY <u>201</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE Johns Hopkins Hospital BALTIMORE MD 21205</u>			D. STREET ADDRESS (If rural, give location) <u>2018 E. Pratt St</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>2/11/95</u>	9. AGE (In years lost birthday) <u>72</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Medie Rice</u>		
14. MOTHER'S MAIDEN NAME <u>Susie</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>OLLIE DEROSSETT</u> ADDRESS <u>BOX 63</u>		
18. <u>260X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			(A) <u>Infection</u> DUE TO		
ANTECEDENT CAUSES			(B) <u>Diabetes</u> DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Malnutrition & Dehydration</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if) (this hospital) attended the deceased from <u>6/3/67</u> to <u>6/5/67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robb Moses</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>6/5/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robb Moses</u> M.D.				23D. ADDRESS <u>Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/9/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>LADGER MEM. CEM. RODENFIELD W. VA.</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 7 1967</u>			
25B. NAME OF REGISTRAR <u>John E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>DIPPEL BROS INC BALTIMORE</u>			

1/10/1

THE
PATIENCE NO. 1102
HOSPITAL

no

ate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and as released to the hospital by a medical examiner. Also, if the direct or contributing cause of death is an accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 5503		CERTIFICATE OF DEATH		Registered No. 67 5503	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Thomas Edgar Kicklighter				2. DATE AND HOUR OF DEATH June 5, 1967 11 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Park Drive				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Florida B. COUNTY Jacksonville C. CITY OR TOWN (If outside city limits, write RURAL and give township) V-08 D. STREET ADDRESS (If rural, give location) 7337 North Shore					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/25/1906	9. AGE (In years lost birthday) 60-59	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oiler		10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) Ga.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John R. Kicklighter				14. MOTHER'S MAIDEN NAME Elmira Lynn					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 261-09-5091		17. INFORMANT Records- US PHS Hospital, Balto, Md.					
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Acute myocardial infarction DUE TO (B) Arteriosclerotic cardiovascular DUE TO disease (C)				INTERVAL BETWEEN ONSET AND DEATH Hours Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 3 5/22/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic aneurysm		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Apr. 13 19 67 to June 5 19 67 that (I) (we) last saw the deceased alive on June 5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Michael E. Pelczar M.D.							23B. DATE SIGNED 6/6/67		
23C. PHYSICIAN'S NAME (Type) Michael E. Pelczar, SA Surg (R) M.D.				23D. ADDRESS US PHS Hospital, Balto, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6/6/1967		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) Jacksonville, Florida			
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. J. Taylor		25D. ADDRESS Balto, Md. North 1st			

Handwritten signature

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K 4001

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 5504

BIRTH NO. 67 5504

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

KELL, Alfred Peter

2. DATE AND HOUR OF DEATH

June 5, 1967

5:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland**

B. COUNTY **28-04**

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4410 Mountview Road

21229

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

10/4/97

9. AGE (In years last birthday)

69

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Erector

10B. KIND OF BUSINESS OR INDUSTRY

Shipyard

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry C. Kell

14. MOTHER'S MAIDEN NAME

Helen A. O'Neil

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

6/7/17-9/4/19

16. SOCIAL SECURITY NO.

214-18-93-40

17. INFORMANT

VA Hospital Records, Baltimore, Md 21218

ADDRESS

18. **16-3X I**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)

(A) **Carcinoma of right lung**
DUE TO

1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from **February 3rd** 19 **67** to **June 5th** 19 **67**, that (2) (we) lost saw the deceased alive on **June 5th** 19 **67** and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (d/d/d) view the body after death.

23A. SIGNATURE

Margaret A. Dennis

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

June 5, 1967

23C. PHYSICIAN'S NAME (Type)

M.D.

23D. ADDRESS

**Veterans Administration Hospital
3900 Loch Raven Blvd., Balto., Md 21218**

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6/8/1967

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D. BY HEALTH DEPT.

JUN 7 1967

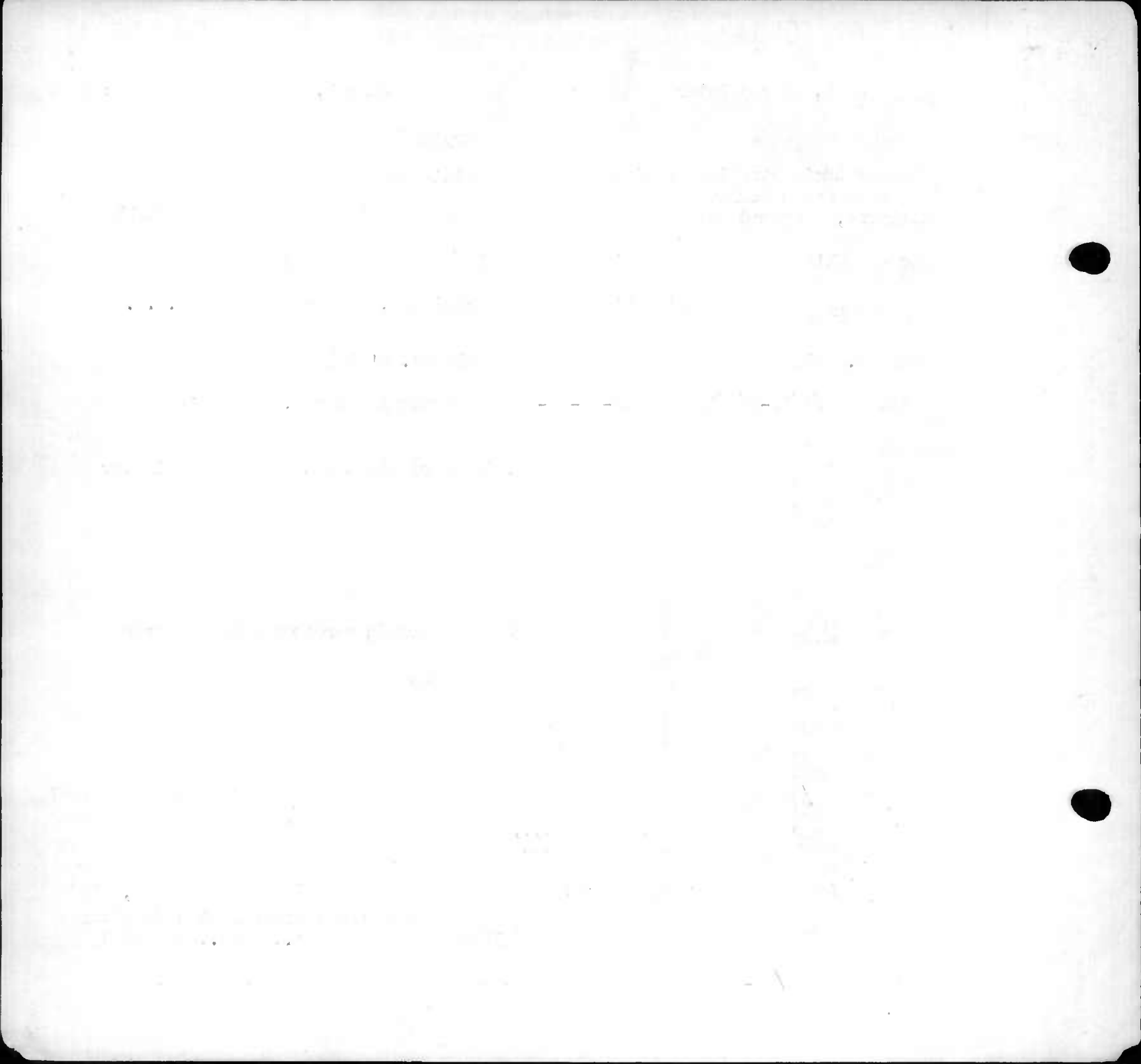
25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Wm. J. Glickman & Sons Baltimore, Md.

ADDRESS



1
S-315

67 5505

BALTIMORE CITY HEALTH DEPARTMENT

67 5505

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GEORGE FRANKLIN STEVENS

2. DATE AND HOUR PRONOUNCED DEAD

June 5, 1967

5:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2671 Hafer Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

Feb. 22, 1933

9. AGE (In years
last birthday)

34

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Industrial

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward C. STEVENS

14. MOTHER'S MAIDEN NAME

Sylvia Lucas

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

NONE

16. SOCIAL
SECURITY NO.

214-30-5751

17. INFORMANT

ADDRESS

Lillian Stewart 2671 Hafer St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Hypoplasia of Coronary Arteries

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

6/6/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-9-67

23C. NAME of CEMETERY or CREMATORY

GLEN HAVEN

23D. LOCATION

(City, town, or county)

(State)

GLEN BURNIE MD

24A. DATE REC'D BY HEALTH DEPT.

JUN 7 1967

24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

Geo. L. Schwab Funeral Home

ADDRESS

Francis H. Miller 2101 Frederick Ave

1. The first part of the paper is devoted to a general
discussion of the problem. It is shown that the
problem is of great importance and that it has
not been completely solved. The author then
presents a new method for solving the problem.
This method is based on the use of the
Fourier transform and the method of steepest
descent. It is shown that this method is
very efficient and that it can be used to
solve a wide variety of problems.

2. In the second part of the paper, the author
applies the method to the problem of the
diffusion of a gas. It is shown that the
method can be used to calculate the rate of
diffusion of a gas through a membrane. The
author then compares the results of the
calculation with the results of experiments.
It is shown that the results of the
calculation are in good agreement with the
results of the experiments.

3. In the third part of the paper, the author
applies the method to the problem of the
diffusion of a liquid. It is shown that the
method can be used to calculate the rate of
diffusion of a liquid through a membrane. The
author then compares the results of the
calculation with the results of experiments.
It is shown that the results of the
calculation are in good agreement with the
results of the experiments.

CERTIFICATE OF DEATH

Registered No. 67 5506

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 13-620 67 5506		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) Manson Brock		2. DATE AND HOUR OF DEATH 6-5-67 7:35 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 10-02 D. STREET ADDRESS (If rural, give location) 911 Central Ave. 21202 007	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-14-93
9. AGE (In years last birthday) 74		10. AGE (In years last birthday) 74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marian Brock		14. MOTHER'S MAIDEN NAME Susan Canty	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT BCM: Records 4940 Eastern Ave. Baltimore, Md. #21224		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Arrest		INTERVAL BETWEEN ONSET AND DEATH 10 min -	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Aspiration		INTERVAL BETWEEN ONSET AND DEATH 10 min -	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-10-1967 to 6-5-1967 , that (I) (we) last saw the deceased alive on 6-5-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Bruce Gordon Whipple		23B. DATE SIGNED 6-6-67	
23C. PHYSICIAN'S NAME (Type) Bruce Gordon Whipple		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-9-67	
24C. NAME OF CEMETERY OR CREMATORY Mount Airy		24D. LOCATION Small	
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR John E. Johnson	
25C. FUNERAL DIRECTOR Charles W. Brown		25D. ADDRESS 1001 Broadway	

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BIRTH NO. 67 5507		BALTIMORE CITY HEALTH DEPARTMENT		67 5507	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
1. NAME OF DECEASED (Type or Print)		ANNIE ROBERTS		2. DATE AND HOUR PRONOUNCED DEAD 6-4-67 7:30 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION 44 99 UNION MEMORIAL HOSPITAL - DOA		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		B. COUNTY Baltimore	
D. STREET ADDRESS (If rural, give location)		117 W. 24th Street		21218	
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 14 - 1907	9. AGE (In years last birthday) 60	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Va	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Rebecca Roy		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Daniel M. Rotat	
18. 171X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) Perforation of rectum with generalized peritonitis DUE TO			
		(B) Metastatic carcinoma of uterine cervix and Radiotherapy			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		6-5-67	
RUSSELL S. FISHER, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		6-8-67		Balti Nat Cat	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
JUN 7 1967		Robert E. Fisher		Clay Wilson	
				ADDRESS	
				1000 Granby St	

VALLEY FORT

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>67 5508</u>				
BIRTH NO. <u>67 5508</u>					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>HOWARD G. LOUISE</u>					2. DATE AND HOUR OF DEATH <u>6-3-67</u> <u>1 A.</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Lutheran Hosp of Md., Inc.</u> <u>46</u>					A. STATE <u>Md.</u> B. COUNTY <u>16-04</u>				
					C. CITY OR TOWN (If outside city limits, with RURAL and give township) <u>Baltimore</u> <u>17</u>				
					D. STREET ADDRESS (If rural, give location) <u>1136 McKean Ave.</u>				
5. SEX <u>F</u>	6. RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-25-26</u>	9. AGE (In years last birthday) <u>40</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Edward Williams</u>					14. MOTHER'S MAIDEN NAME <u>Missouri Harps</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edward Williams</u>		ADDRESS <u>Same - Father</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>465X 17-322.1</u> <u>Pulmonary Infarction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 Hrs. ±</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO (B) DUE TO (C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<u>Chronic Alcoholism (by History)</u>				
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from <u>6-2</u> 19 <u>67</u> to <u>6-3</u> 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>6-2</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>[Signature]</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6-3-67</u>		
23C. PHYSICIAN'S NAME (Type) <u>R. J. DUREZA</u>					23D. ADDRESS M.D. <u>2413 Cylburn Ave. Balto. Md. 21215</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-8-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Balto. Nat. Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 7 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairley</u>		25C. FUNERAL DIRECTOR <u>Elmer O. Walker</u>		ADDRESS <u>1000 Brantley Ave.</u>			

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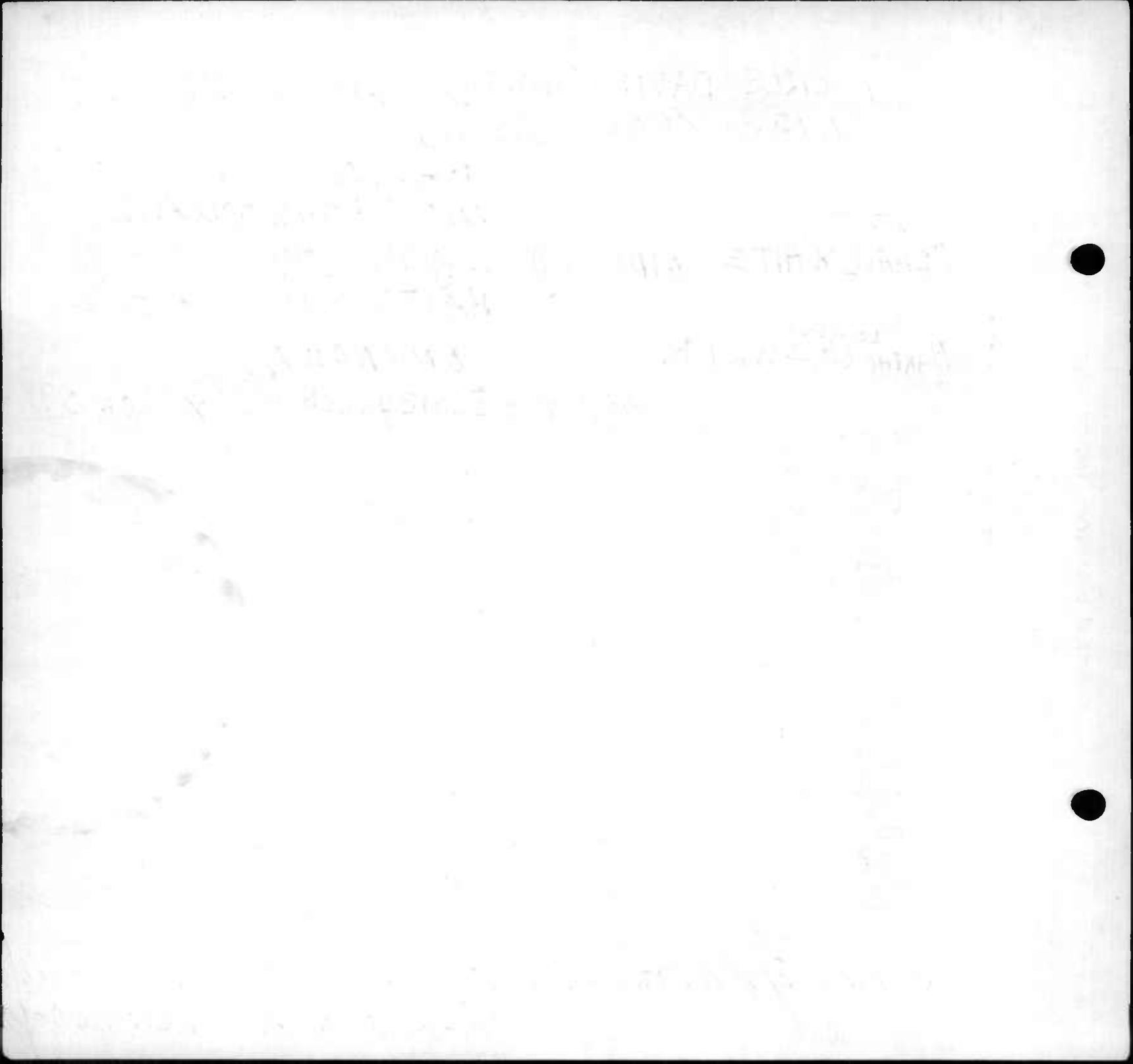
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

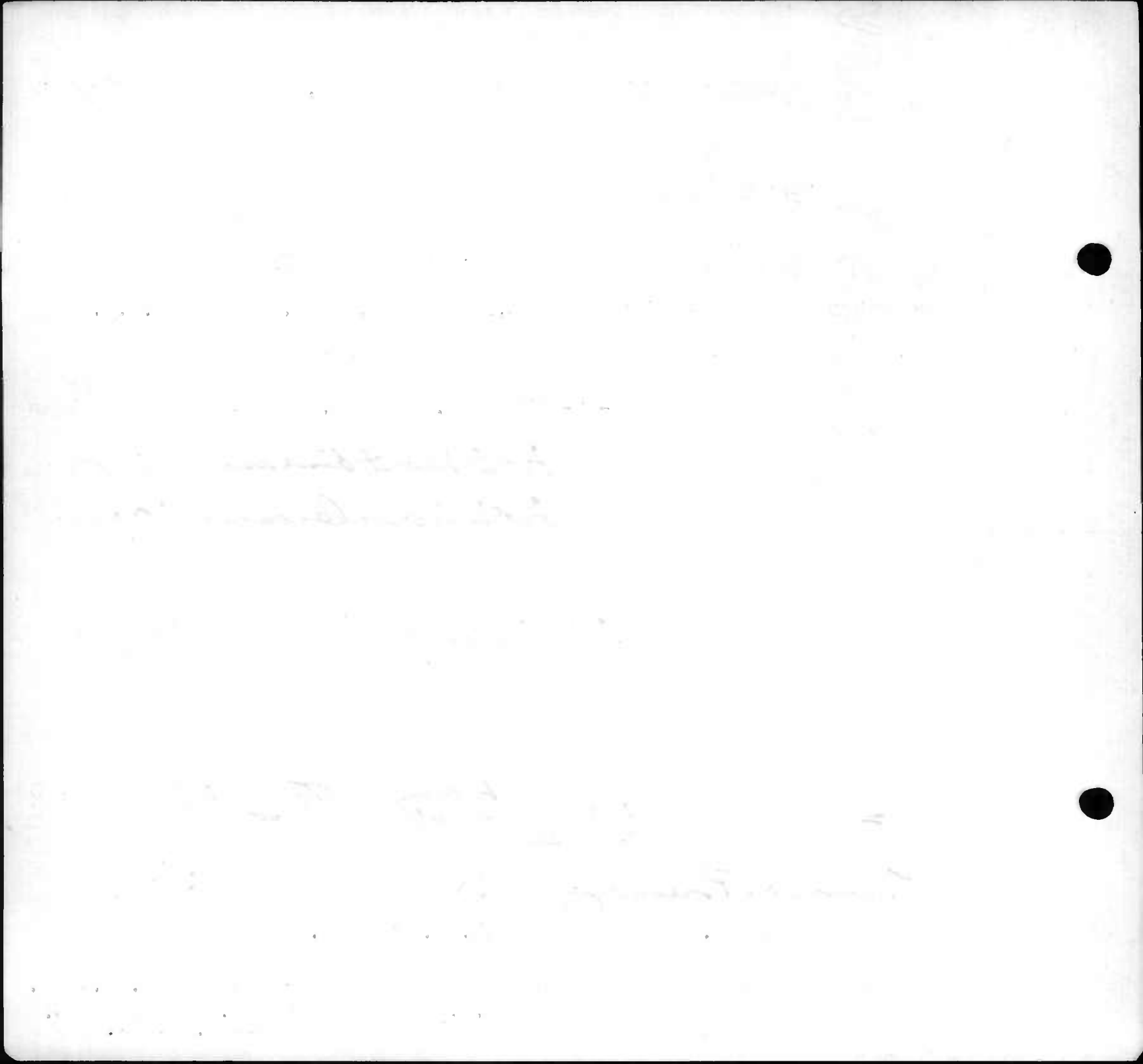
BIRTH NO. 67 5509		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5509	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) LUCILLE DAVID (DAWID)			2. DATE AND HOUR OF DEATH JUNE 5 1967 6:00 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 1110 S. KENWOOD AVE			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 00			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BAHLO		
			D. STREET ADDRESS (If rural, give location) 1110 S. KENWOOD AVE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH Aug. 25, 1898	9. AGE (In years, last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BAHLO, MD.	
13. FATHER'S NAME LOUIS EW BARTHOLOMAEW		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 21548-4709		17. INFORMANT DAUGHTER	
18. 7-20-11		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Coronary Thrombosis		Instantaneous	
ANTECEDENT CAUSES		(B) Arteriosclerotic C.V. Disease		3 yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Generalized Arteriosclerosis		Unknown	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/20 19 61 to 6/5 19 67 , that (I) (we) last saw the deceased alive on 6/5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry J. Houska M.D.				23B. DATE SIGNED 6/5/67	
23C. PHYSICIAN'S NAME (Type) HENRY J. HOUSKA M.D.				23D. ADDRESS 333 S. EAST AVE 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/9/67		24C. NAME OF CEMETERY or CREMATORY ST. STANISLAUS CEM.	
24D. LOCATION (City, town, or county) (State) 6375 BOSTON ST. MD.		25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR M. J. E. Taylor	
25C. FUNERAL DIRECTOR Mary E. Houska		25D. ADDRESS 1000 S. KENWOOD AVE			



FUNERAL DIRECTOR: IMPORTANT

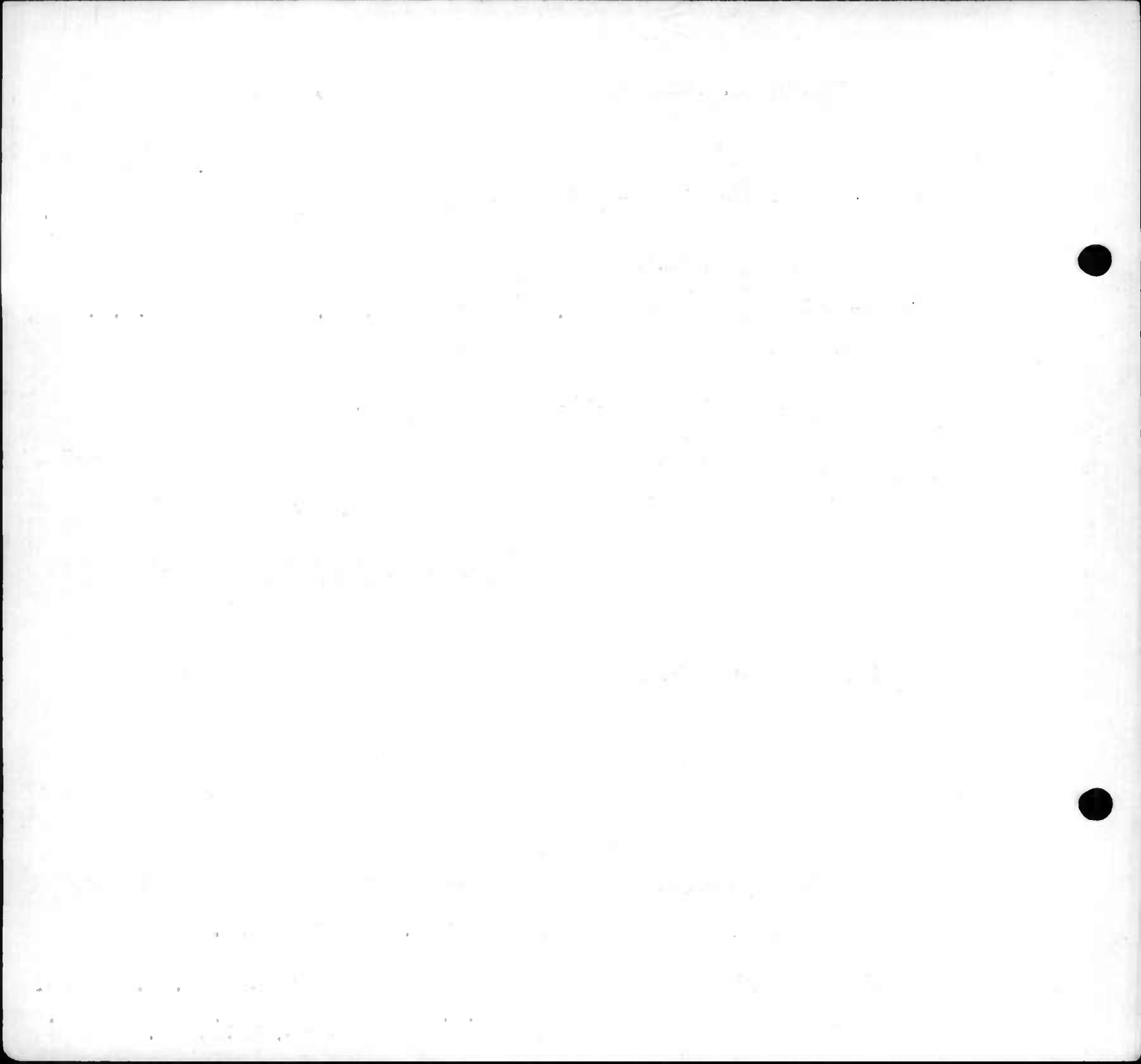
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 5510		REGISTERED NO. 67 5510	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		June 4, 1967 9:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00 4303 Underwood Road		A. STATE Maryland	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-11	
D. STREET ADDRESS (If rural, give location) 4303 Underwood Road			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4/16/1894
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 73
11. BIRTHPLACE (State or foreign country) Minneapolis, Minn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ward David Williams		14. MOTHER'S MAIDEN NAME Lillie Fahnestock	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-2728	17. INFORMANT Mrs. Edward R. Novak, 5223 Springlake Way
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.01 A-5 heart disease. 1 yr.		CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Cirrhotic liver 10 yr.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Jan 1958 to 6/4 1967, that (I) lost saw the deceased alive on 6/4 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (the) (did) view the body after death.			
23A. SIGNATURE Norman R. Freeman M.D.			23B. DATE SIGNED 6/5/67.
23C. PHYSICIAN'S NAME (Type) Norman R. Freeman M.D.			23D. ADDRESS 11. W. 29th St.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/6/1967	24C. NAME OF CEMETERY or CREMATORY Druid Ridge	24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967	25B. NAME OF REGISTRAR Robert E. Jenkins	25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5511	
BIRTH NO. 67 5511		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles C. Schafer		2. DATE AND HOUR OF DEATH June 3, 1967 9P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-11 D. STREET ADDRESS (If rural, give location) 4700 York Road			
FULL NAME OF HOSPITAL OR INSTITUTION 90 House in the Pines - Belvedere		(If not in hospital or institution, give street address or location)			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9/9/1892	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Toolman		10B. KIND OF BUSINESS OR INDUSTRY Eastern Venetian Blind Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Schafer		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-8573		17. INFORMANT Charles W. Schafer ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		(A) DUE TO Carcinoma of Pancreas		INTERVAL BETWEEN ONSET AND DEATH 4 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Arteriosclerotic Heart Dis		6 years	
		(C) DUE TO Hypertension Port Radwark Iz Pharynx		8 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION April 67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gum Disease		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 1967 to June 3 1967 , that (I) (we) last saw the deceased alive on June 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sol Smith M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 6/6/67	
23C. PHYSICIAN'S NAME (Type) Sol Smith		23D. ADDRESS M.D. 1261 E. Belvedere Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/7/1967		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. LOCATION (City, town, or county) (State) Parkville, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 21212, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

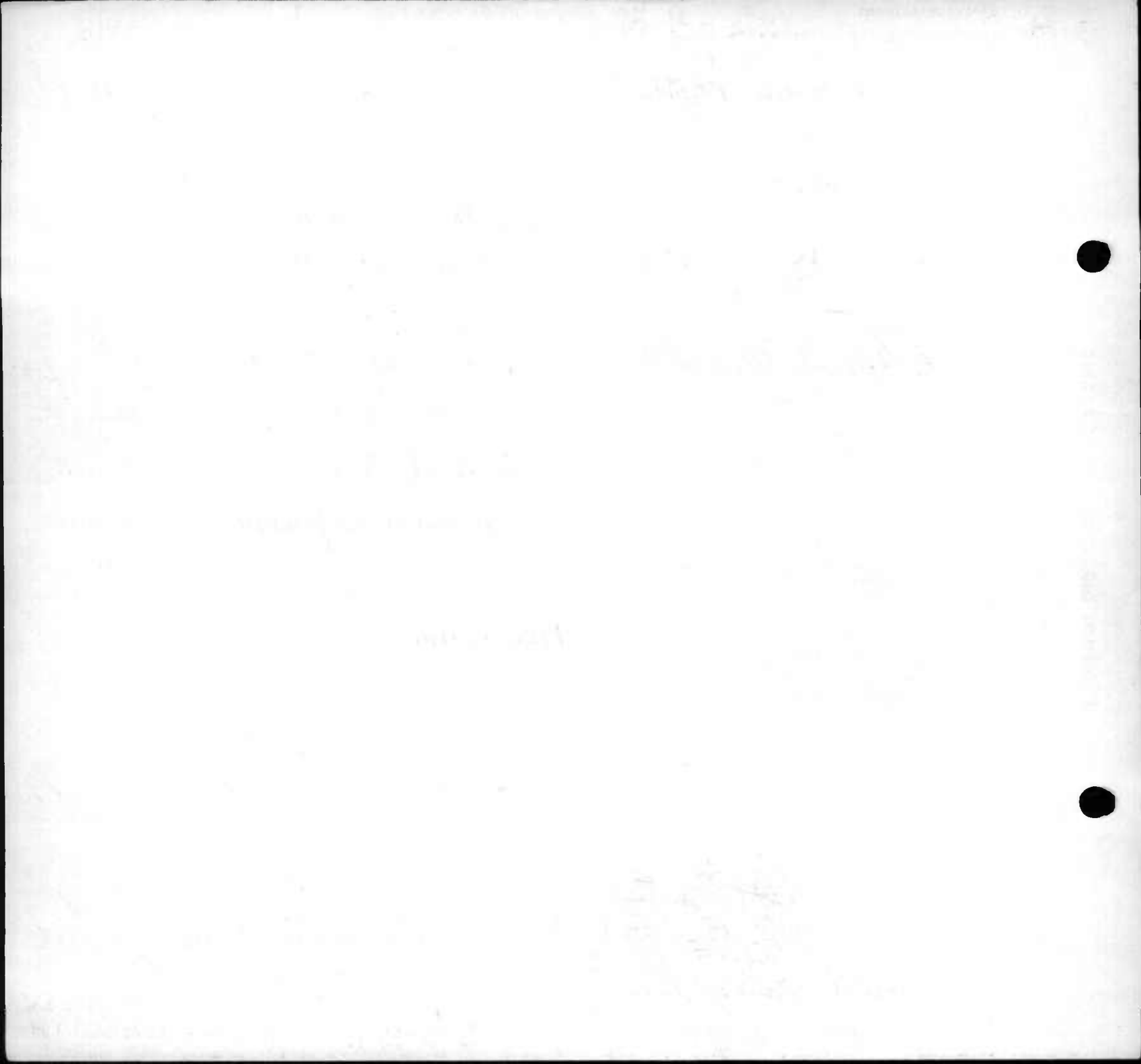
BALTIMORE CITY HEALTH DEPARTMENT											
67 5512 CERTIFICATE OF DEATH										Registered No. 67 5512	
BIRTH NO.											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print)		Very Rev. Anthony Witkowski O. F. M. Conf. DATE AND HOUR OF DEATH <i>Father Anthony Witkowski June 5th 1967 12:02 P.</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Howard Co.</i>									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Ellicott City 63-00</i>									
<i>34 Bon Secours Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>Holly Quarter Rd.</i>									
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>9/17/82</i>	9. AGE (In years last birthday) <i>85</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Father Priest</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Religious Order</i>			11. BIRTHPLACE (State or foreign country) <i>Poland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		
13. FATHER'S NAME <i>Unknown</i>			Martin Witkowski			14. MOTHER'S MAIDEN NAME <i>Unknown</i>			Frances Grabowski		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>-----</i>			17. INFORMANT <i>Rev. Dominic Slemba - St. Joseph Cupertino Nov</i>			ADDRESS <i>Ellicott City, Md.</i>		
18. <i>434.1 I</i>			CAUSE OF DEATH						INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury at complication which caused death.)			(A) <i>Congestive heart failure</i>								
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <i></i>								
(C) <i></i>											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>NO</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>6/01/67</i> 1967 to <i>6/05</i> 1967, that (I) <i>we</i> lost saw the deceased alive on <i>6/05</i> 1967 and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>We</i> (did) (did not) view the body after death.											
23A. SIGNATURE <i>S. R. prsk</i>									23B. DATE SIGNED <i>6/05/67</i>		
23C. PHYSICIAN'S NAME (Type) <i>S. A. I. ROX PARK</i>									23D. ADDRESS <i>Bon Secours Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>6/8/67</i>			24C. NAME OF CEMETERY or CREMATORY <i>St. Stanislaus Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
25A. DATE REC'D. BY HEALTH DEPT. <i>JUN 7 1967</i>			25B. NAME OF REGISTRAR <i>G. A. Weber</i>			25C. FUNERAL DIRECTOR <i>George A. Weber</i>			ADDRESS <i>705 S. Ann St. #21231</i>		

20/1/85

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5513	
BIRTH NO. 67 5513		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FRANKL FRANCES		2. DATE AND HOUR OF DEATH 6-7-67 5-15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland 46		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1615 Park Ave.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9-11-1890	9. AGE (In years last birthday) 76 years	10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas J. Frankl		14. MOTHER'S MAIDEN NAME Pauline Stallerger	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Grace Deal 528 1/2 Washington	
18. 42011 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) Cerebral Thrombosis		1 month	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Myocardial infarction		1 month	
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-6- 19 67 to 6-7- 19 67 , that (I) (we) last saw the deceased alive on 6-7- 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anil M. Joshi				23B. DATE SIGNED 6-7-67	
23C. PHYSICIAN'S NAME (Type) ANIL M. JOSHI		23D. ADDRESS Lutheran Hospital of Maryland, 730 Ashburton street, Baltimore 21216			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		June 10		Balto	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 7 1967		Philip Herwig		2024 Orleans St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5514		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5514	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ALICE T. KLENDER		2. DATE AND HOUR OF DEATH 6-6-67 9:23 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY -			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital at institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 7-01			
		D. STREET ADDRESS (If rural, give location) 3118 E. MONUMENT ST. 21205			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 2-8-00	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME JOHN O'DONNELL		14. MOTHER'S MAIDEN NAME CATHERINE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 443 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cardiac arrest (B) intracerebral hemorrhage (C) HASCUD		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/24 19 67 to 6/6 19 67, that (I) (we) lost saw the deceased alive on 6/6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kenneth Brigham M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-6-67	
23C. PHYSICIAN'S NAME (Type) Kenneth Brigham		23D. ADDRESS M.D. Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 9/67		24C. NAME OF CEMETERY or CREMATORY Baltimore Nat'l Cem	
24D. LOCATION (City, town, or county) (State) Baltimore					
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR John E. Stanbury		25C. FUNERAL DIRECTOR Philip A. Herwig & Sons, 2024 Orleans St	

MD -

BA-1100000

the John H. Johnson Foundation

3118 E. MONUMENT ST.

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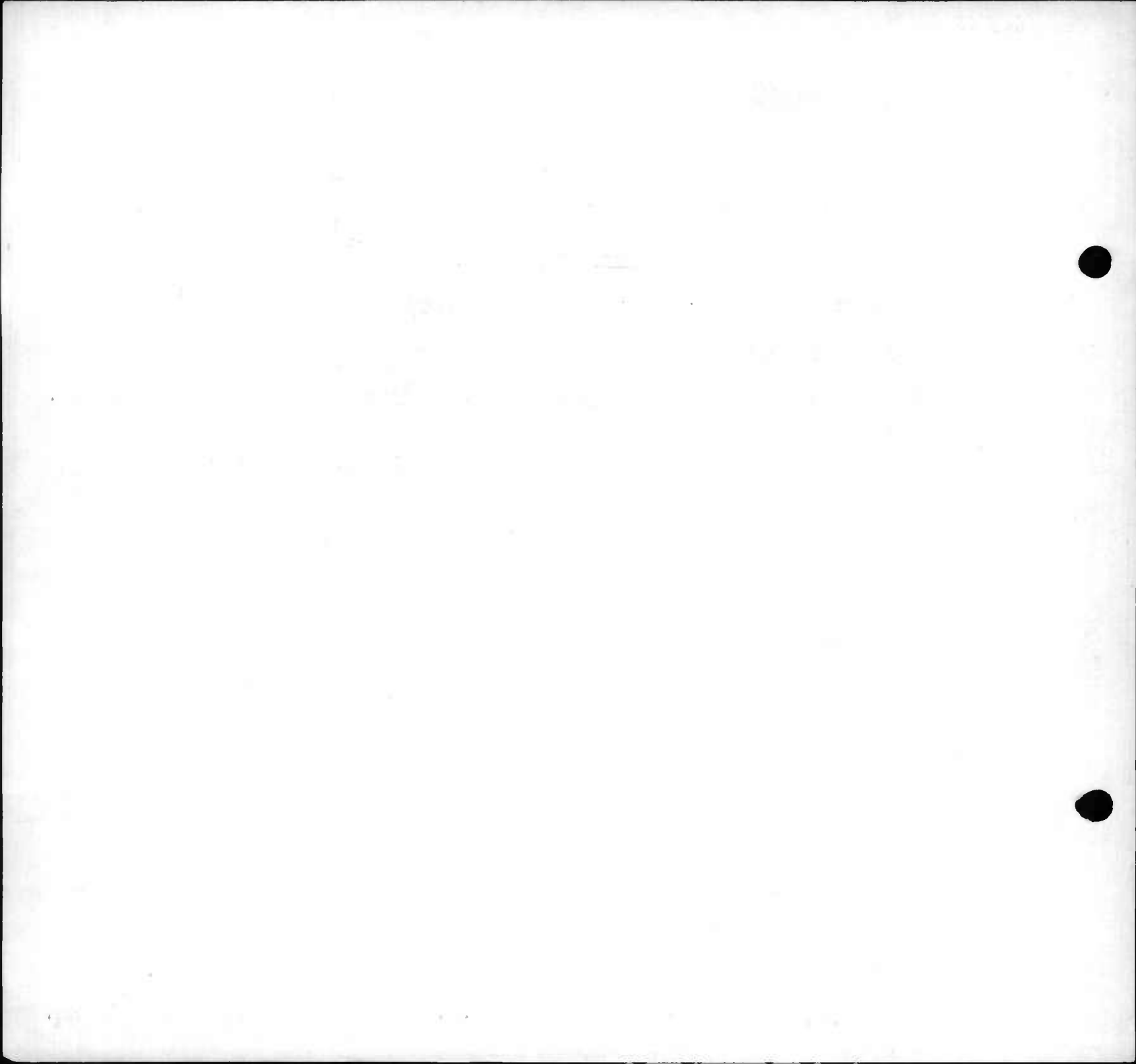
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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5515	
BIRTH NO. 67 5515		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Estelle Greene</i>		2. DATE AND HOUR OF DEATH <i>June 5, 1967 12¹⁰ P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived; If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 Bon Secours Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>4325 Flowering Rd 21229</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>2/12/1893</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Nicholas Green</i>			
14. MOTHER'S MAIDEN NAME <i>Kate ?</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			
16. SOCIAL SECURITY NO. <i>NO.</i>		17. INFORMANT ADDRESS <i>Geraldine Peake 6120 Burnt Oak Rd.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(A) <i>Massive post. myocardial infarct. 3 days</i>			
		(B) <i>Occ. (25) circunflex coronary art.</i>			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 3</i> 19 <i>67</i> to <i>June 5</i> 19 <i>67</i> , that (I) (we) lost saw the deceased alive on <i>June 5</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Juny Rook Lee</i>		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6-5-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Juny Rook Lee</i>		23D. ADDRESS M.D. _____			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/8/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park</i>	
24D. LOCATION (City, town, or county) <i>Baltimore Md.</i>		(State) _____			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 8 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>J. T. Stansbury 6411 Windsor Mill Rd.</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5516	
BIRTH NO. 67 5516		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Elsie Ajello			
2. DATE AND HOUR OF DEATH June 2, 1967		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.			
48 Maryland General Hospital		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 203 South Ann Street			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-24-1898	9. AGE (In years last birthday) 69	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George W. Eaton		14. MOTHER'S MAIDEN NAME Mary A. Shipley			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-12-8559		17. INFORMANT ADDRESS Joseph J. Ajello 203 South Ann St. Balto.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
cerebro-vascular accident		(A) DUE TO		immediate	
hemorrhage		(B) DUE TO		immediate	
hypertension		(C) DUE TO		12 yrs.	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		obesity, exogenous several yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-4-54 to June 2, 1967, that (I) (we) last saw the deceased alive on June 2, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Ellsworth Cook		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-8 6-5-67	
23C. PHYSICIAN'S NAME (Type) E. ELLSWORTH COOK		23D. ADDRESS M.D. 2431 Maryland Avenue.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-6-1967		24C. NAME OF CEMETERY or CREMATORY St. Mary's Cem. (Hampden)	
				24D. LOCATION (City, town, or county) (State) Balto. City Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. 1217 St. Paul St.	

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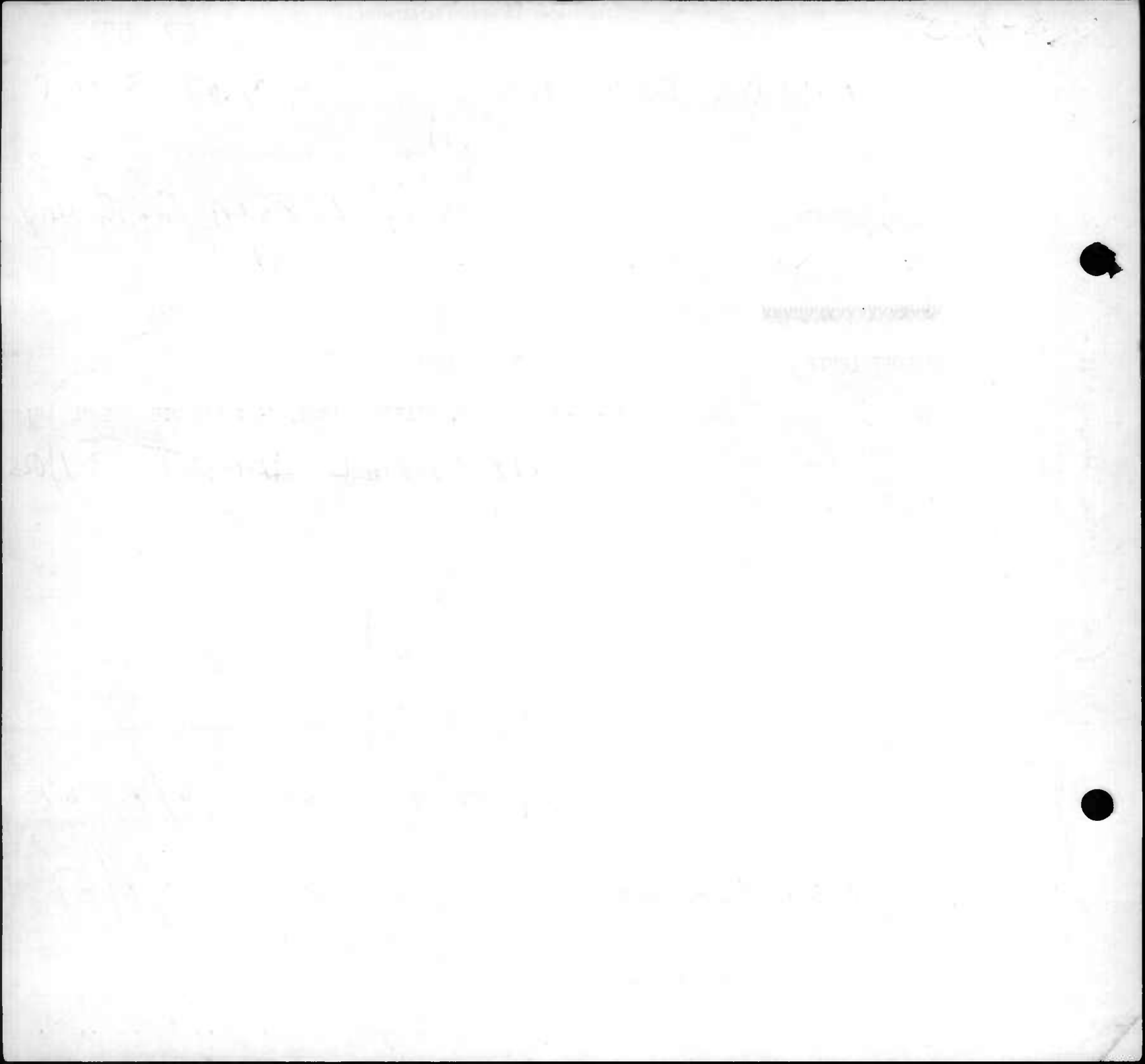
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

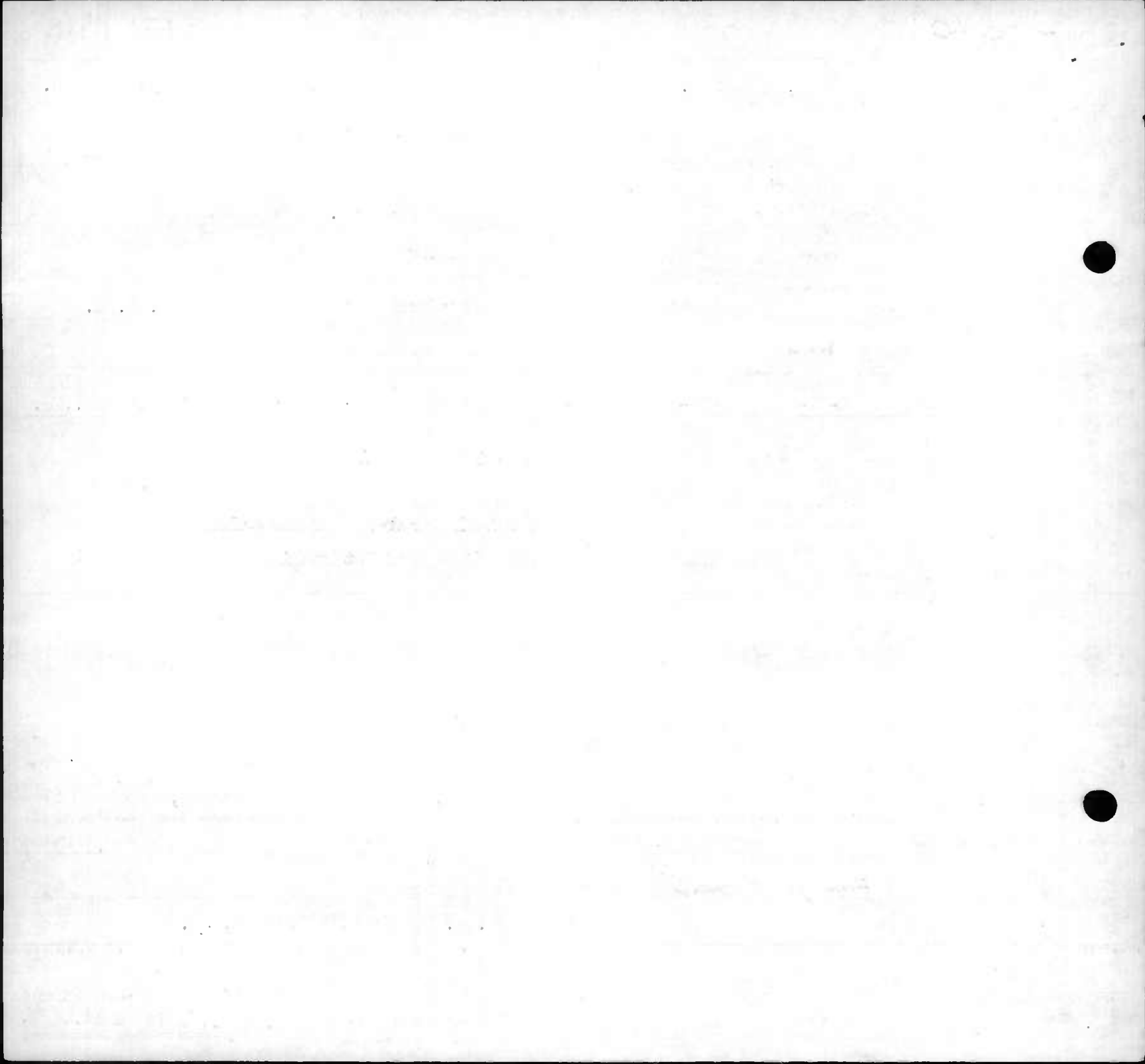
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5517	
BIRTH NO. 67 5517		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNA KOLMAN		2. DATE AND HOUR OF DEATH 6/8/67 8:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		A. STATE MD B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT	
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 2634 LOYOLA SOUTH WAY		15-13	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-1-93	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME YANKOFF LEVIT		14. MOTHER'S MAIDEN NAME ANNA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-42-7425		17. INFORMATION ADDRESS MR. MILTON KOLMAN, 4307 FAIRVIEW AVENUE #16	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCT ? HRS		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 6/8/67 to 6/8/67 that (I) (we) last saw the deceased alive on 6/8/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Stephen Gordon		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/8/67	
23C. PHYSICIAN'S NAME (Type) STEPHEN GORDON		23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/6/67		24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR R. G. B. E. STADLER	
25C. FUNERAL DIRECTOR SOLE LEVINSON & BROS. INC., 600 REIST., RD.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

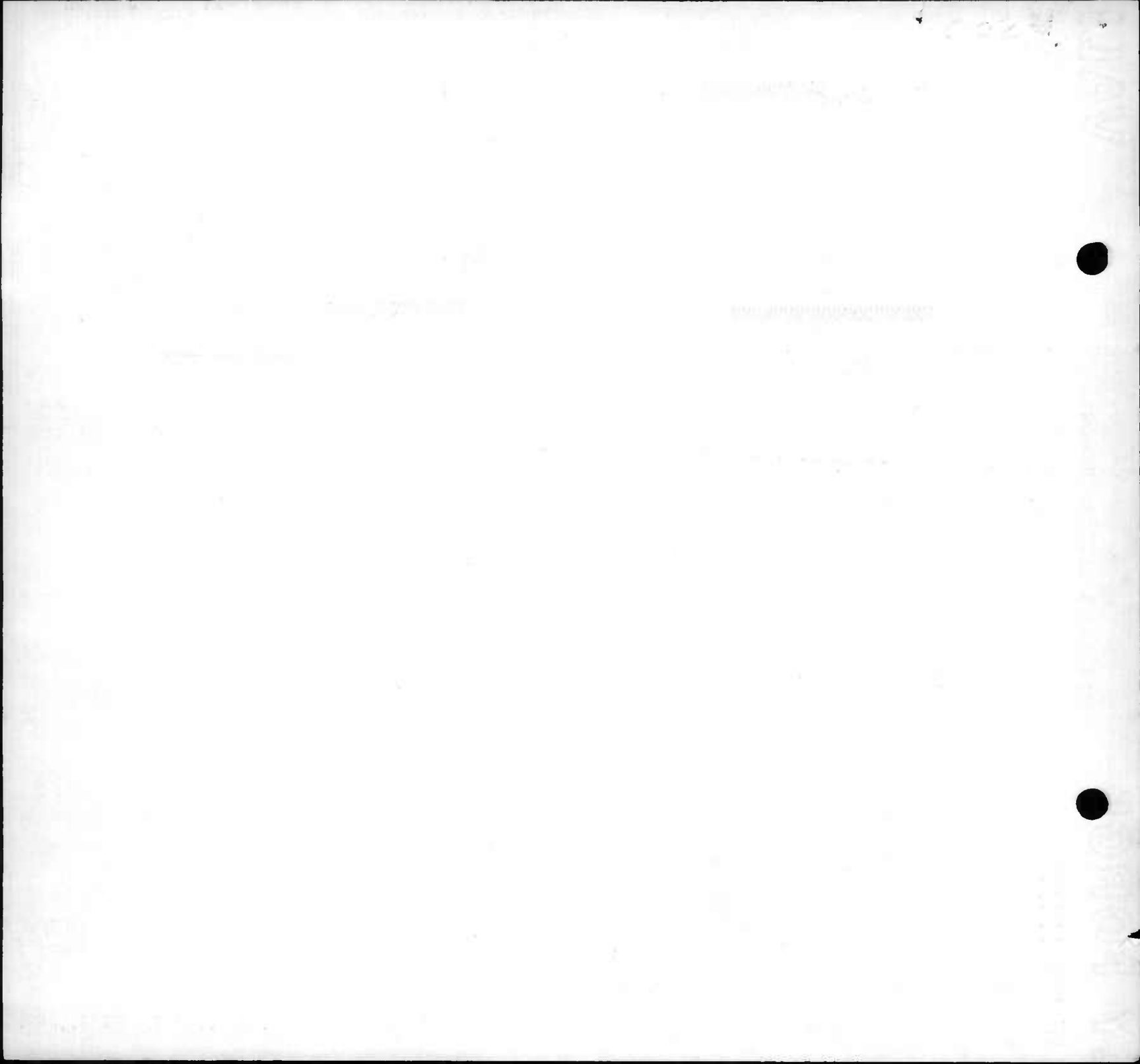
BALTIMORE CITY HEALTH DEPARTMENT									
67 5518 CERTIFICATE OF DEATH					Registered No. 67 5518				
1. NAME OF DECEASED (Type or Print) SATTEL, REUBEN E.					2. DATE AND HOUR OF DEATH June 4, 1967 . 3:15 A. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2200 Park Ave., Apt. 3A				
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 11-2-97	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10B. KIND OF BUSINESS OR INDUSTRY Retail Store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Soloman Sattel					14. MOTHER'S MAIDEN NAME Jennie Gradman				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 2-30-42 to 1-17-43			16. SOCIAL SECURITY NO. 213-09-9670		17. INFORMANT Records ADDRESS 21218 Veterans Administration Hospital, Balto., Md.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 15381 Bronchial Pneumonia (A) DUE TO Terminal Carcinoma Of The Colon (B) DUE TO And Widespread Metastasis (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from May 24, 1967 to June 4, 1967 , that XX (we) last saw the deceased alive on June 4, 1967 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above XX (We) (did) not view the body after death.									
23A. SIGNATURE Domingo A. Garcia					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) Domingo A. Garcia					23D. ADDRESS M.D. V. A. Hospital, Baltimore, Md. 21218				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 6/6/67		24C. NAME OF CEMETERY OR CREMATORY Workmen Circle		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967			25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. Inc., 6010 Reist., Rd.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

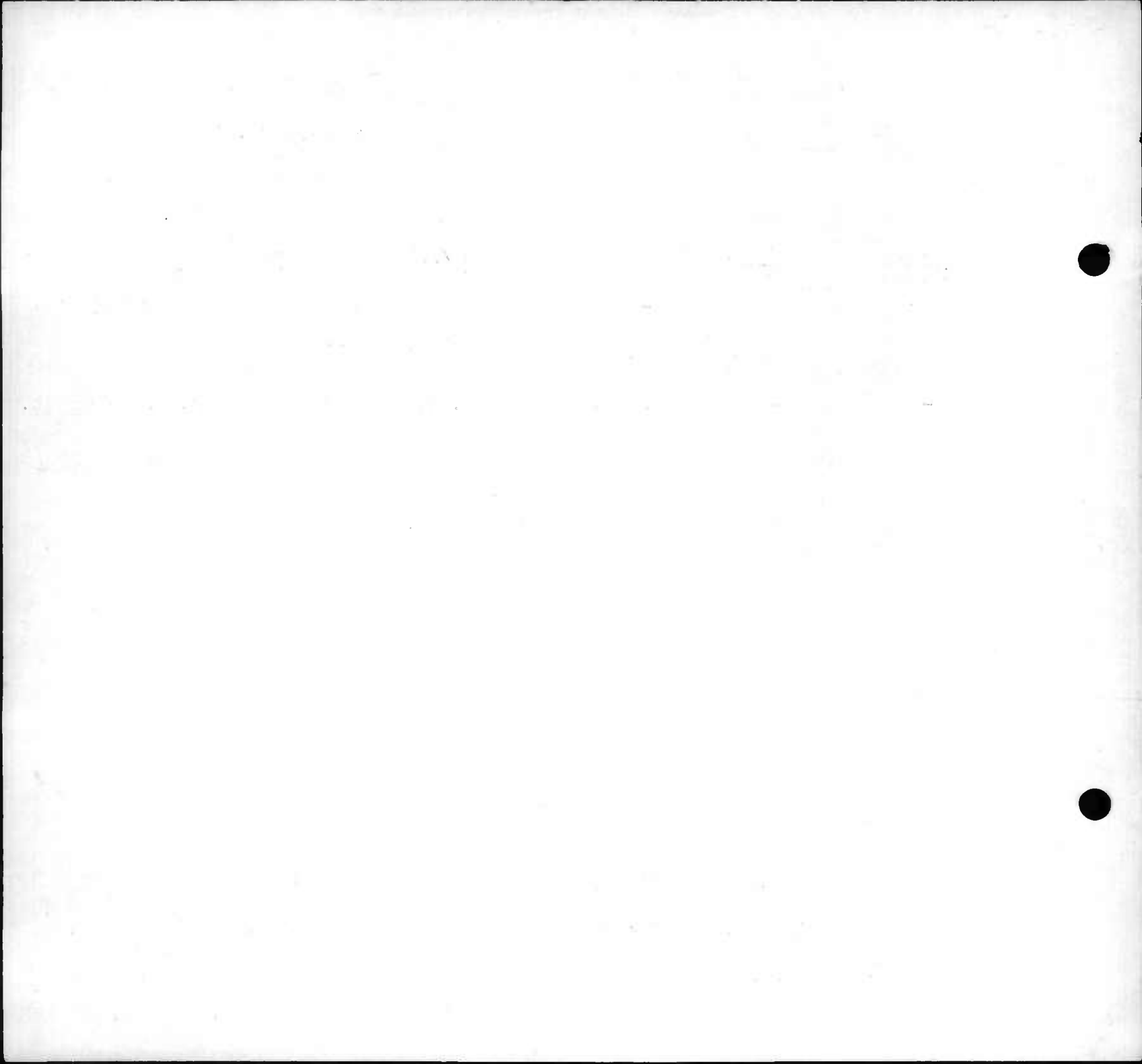
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5519	
67 5519				67 5519	
BIRTH NO. 67 5519				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) JOSEPH A. FINE				2. DATE AND HOUR OF DEATH JUNE 5, 1967 5:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL OF MARYLAND 38				A. STATE MARYLAND B. COUNTY BALTIMORE	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location) 3102 BOONIE ROAD #8	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH JUN 6, 1892		9. AGE (In years lost birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		11. BIRTHPLACE (State or foreign country) LITHUANIA	
13. FATHER'S NAME SOLOMON FINE			14. MOTHER'S MAIDEN NAME BESSIE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 218-18-3043		17. INFORMANT ADDRESS CHART + DAUGHTER - EVELYN BRITMAN
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ADENO CARCINOMA COLON ~ 12 MONTHS				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION MARCH 1966		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ADENO CARCINOMA COLON		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (H) (his hospital) attended the deceased from MAY 31 1967 to JUNE 5 1967 , that (H) (we) last saw the deceased alive on JUNE 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Brent C. Sanders M.D.				23B. DATE SIGNED 6/5/67	
23C. PHYSICIAN'S NAME (Type) BRENT C. SANDERS M.D.				23D. ADDRESS UNIVERSITY OF MARYLAND HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/6/67		24C. NAME OF CEMETERY or CREMATORY ABRAHAM SHOLON	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967			
25B. NAME OF REGISTRAR SOL LEVINSON		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REIST., RD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5520	
BIRTH NO. 67 5520					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Valeria Chetnik			2. DATE AND HOUR OF DEATH June 5th, 1967 03:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 1-03		
(If not in hospital or institution, give street address or location)			D. STREET ADDRESS (If rural, give location) 2633 Eastern Ave		
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12/16/1887	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife none		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Andrzej Kuczynski unknown			14. MOTHER'S MAIDEN NAME Katarzyna ?? unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 160-16-9677	17. INFORMANT ADDRESS Mrs. Sophia Chronowski, 516 S. Durham St.		
18. 540.01			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)			(A) Severe anemia DUE TO several years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Bleeding ulcer DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C)		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/29 19 67 to 6/5 19 67 , that (I) (we) last saw the deceased alive on 6/5 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. R. [Signature]			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/5/67
23C. PHYSICIAN'S NAME (Type) SAL ROX PARK			23D. ADDRESS Bon Secours Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/9/67		24C. NAME OF CEMETERY or CREMATORY Holy Rosary	
24D. LOCATION Baltimore, Maryland		24E. NAME OF REGISTRAR John E. [Signature]			
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR John E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS Mrs. F. SADOWSKI & SONS, 1808 EASTERN AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5521		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5521	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CHRISTY, GEORGE		2. DATE AND HOUR OF DEATH 3 June, 1967 9:35 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3023 LIBERTY PARKWAY 21222		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 10-12-08	9. AGE (In years lost birthday) 58	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker		10B. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Christopher Christy			14. MOTHER'S MAIDEN NAME Margaret Faustini		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Doris Christy 3023 Liberty Parkway	
18. 420,11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial Infarction ASCVD			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Immediate 9 da unknown		
19. DATE OF OPERATION 5			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Probable mitral insufficiency		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/25 19 67 to 6/3 19 67 , that (I) (we) last saw the deceased alive on 6/3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S.W. Douglas, III				23B. DATE SIGNED June 3, 1967	
23C. PHYSICIAN'S NAME (Type) S.W. DOUGLAS III		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/6/67		24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION (City, town, or county) (State) Dundalk, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Ulrich Funeral Home Dundalk, Md.	

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McWhorter, Jr.

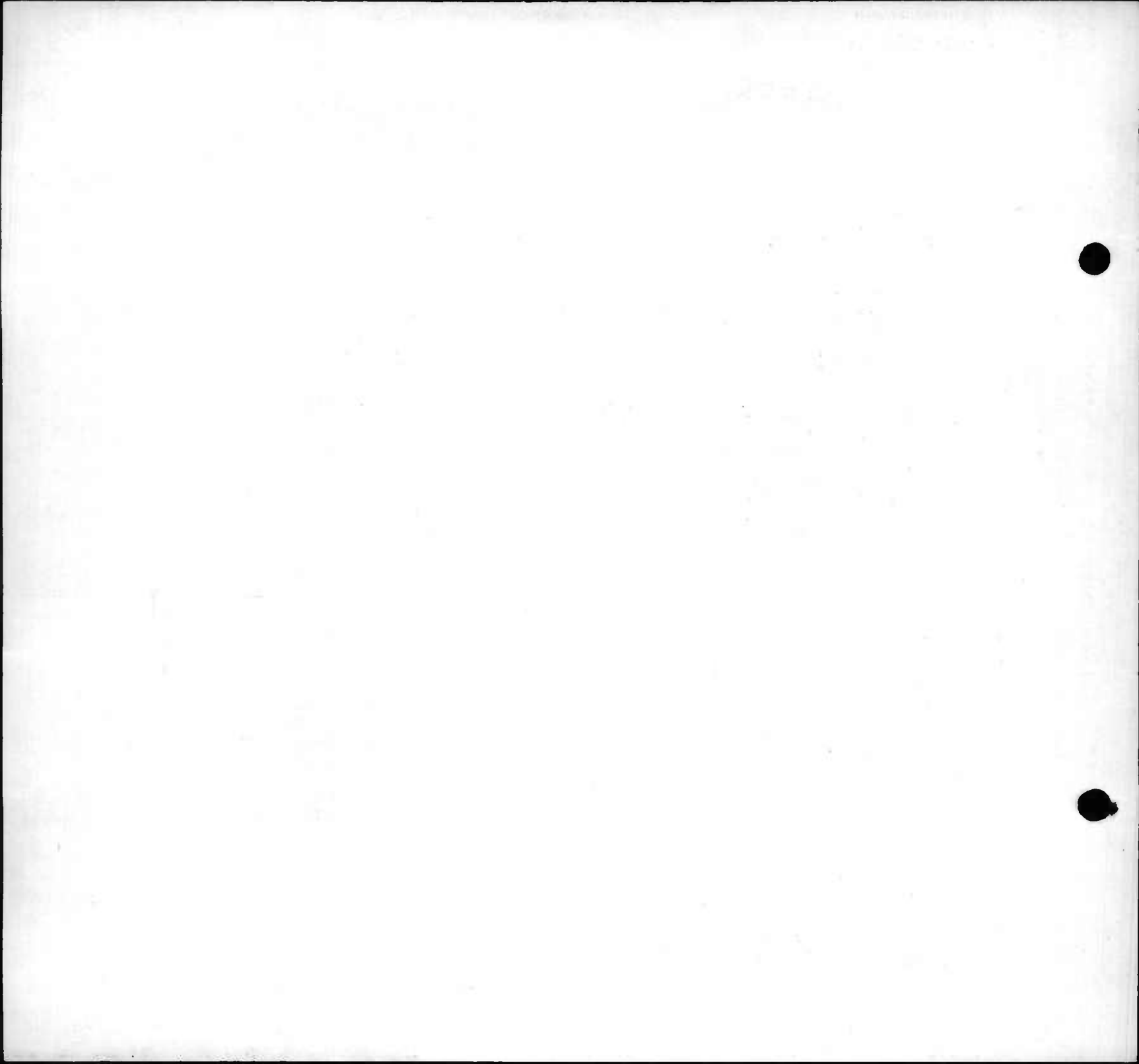
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June 3, 1971

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5522	
BIRTH NO. 67 5522		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GEORGE DESSEL		2. DATE AND HOUR OF DEATH 6-6-67 8:45 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital 35		A. STATE Maryland		B. COUNTY Baltimore	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 123 S. Linwood Ave	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-28-98	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERINTENDENT		10B. KIND OF BUSINESS OR INDUSTRY AMERICAN SHELTING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JACOB DESSEL		14. MOTHER'S MAIDEN NAME MARIA SAUERS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 272-10-1475		17. INFORMANT Chart	
18. 420.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Coronary Artery Disease		years	
ANTECEDENT CAUSES		(B) DUE TO With Cardiac decompensation			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) X	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-6-1967 to 6-6-1967 , that (I) (we) last saw the deceased alive on 6-6-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. E. Subong, Sr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-6-67	
23C. PHYSICIAN'S NAME (Type) Dr. A. E. SUBONG, SR.		23D. ADDRESS Church Home & Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/9/67		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY	
24D. LOCATION (City, town, or county) (State) COLGATE MD					
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ALLERSON FUNERAL HOME - 4216 BELAIR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5523	
BIRTH NO. 67 5523		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WARD, NORRIS R Sr.		2. DATE AND HOUR OF DEATH 6-6-67 12:40A.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE 52.00 D. STREET ADDRESS (If rural, give location) 325 CHANEY LANE 21061			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-1-04	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINT. MAN		10B. KIND OF BUSINESS OR INDUSTRY Maintenance Man		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME - - - Ward		14. MOTHER'S MAIDEN NAME LAURIE - - -	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216 07 2927		17. INFORMANT ADDRESS ST. AGNES RECORDS-CATON & WILKENS AVES	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Acute M. I. DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 5 1967 to JUNE 6 1967 , that (I) (we) last saw the deceased alive on JUNE 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) ESTHER EDERY				23B. DATE SIGNED 6/6/67	
23D. ADDRESS ST. AGNES HOSPITAL-CATON & WILKENS AVES 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/8/67		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park	
24D. LOCATION (City, town, or county) Baltimore		24E. (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR 		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave. 21229	

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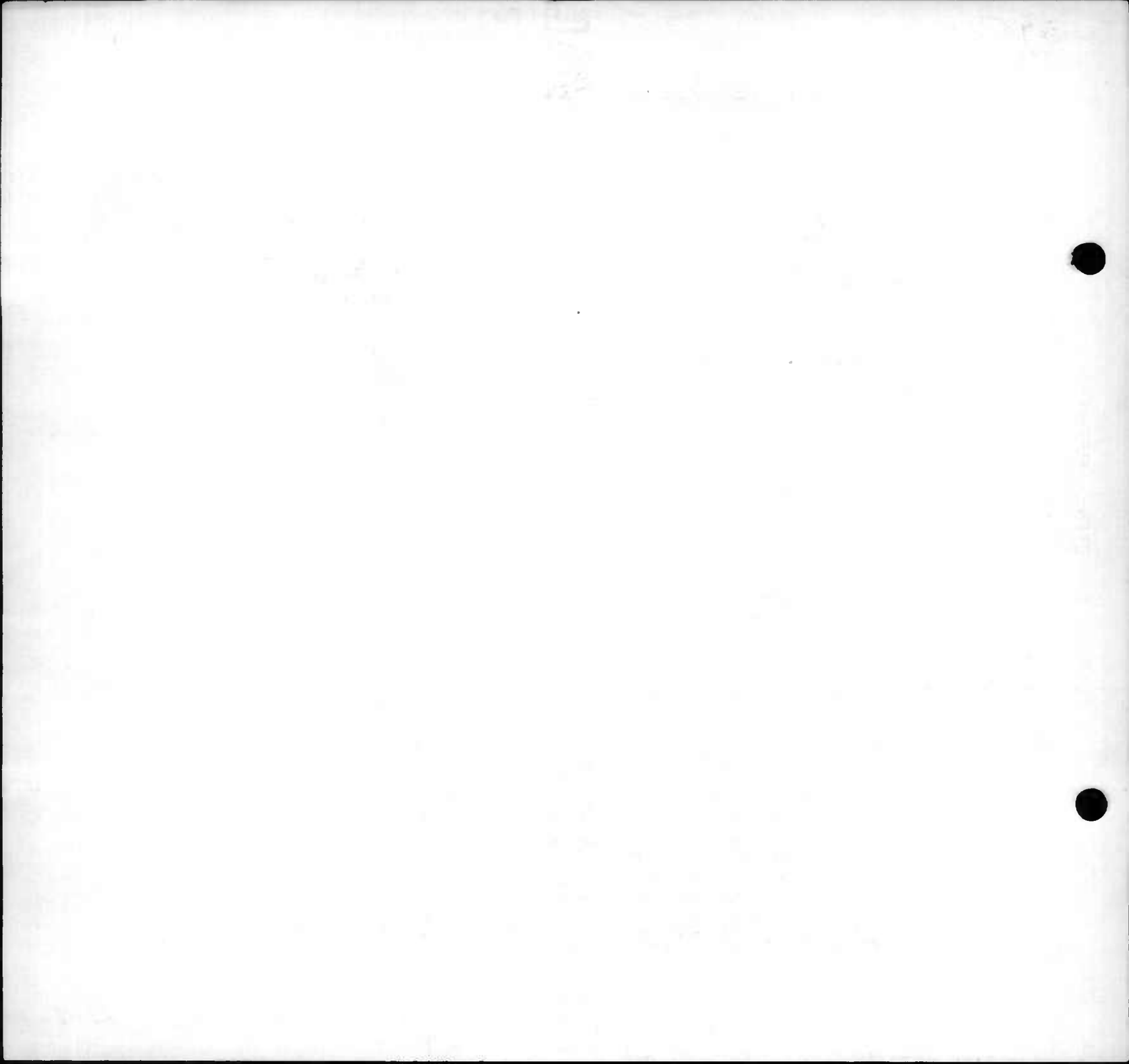
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5524	
BIRTH NO. 67 5524		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Winnie Viola Stevens		2. DATE AND HOUR OF DEATH 6-6-1967 1:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) #2123024-04 D. STREET ADDRESS (If rural, give location) 426 E. Randall St.			
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 7-23-1899	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lathe Operator		10B. KIND OF BUSINESS OR INDUSTRY Bendix Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Charles G. Stevens		14. MOTHER'S MAIDEN NAME Margaret Klemm	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218 12 3618		17. INFORMANT Family - Same	
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Cerebrovascular Accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension ASCVD		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from 6-4 19 67 to 6-6 19 67 , that (we) (we) last saw the deceased alive on 6-6 19 67 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David J. Steinbauer M.D.				23B. DATE SIGNED 6-6-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 1213 Light Street.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6-6-67		24C. NAME OF CEMETERY OR CREMATORY Coke Hill	
24D. LOCATION (City, town, or county) (State) Bethesda Md					
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR 615 E. 130 E Topt Hrs.	



FUNERAL DIRECTOR: IMPORTANT

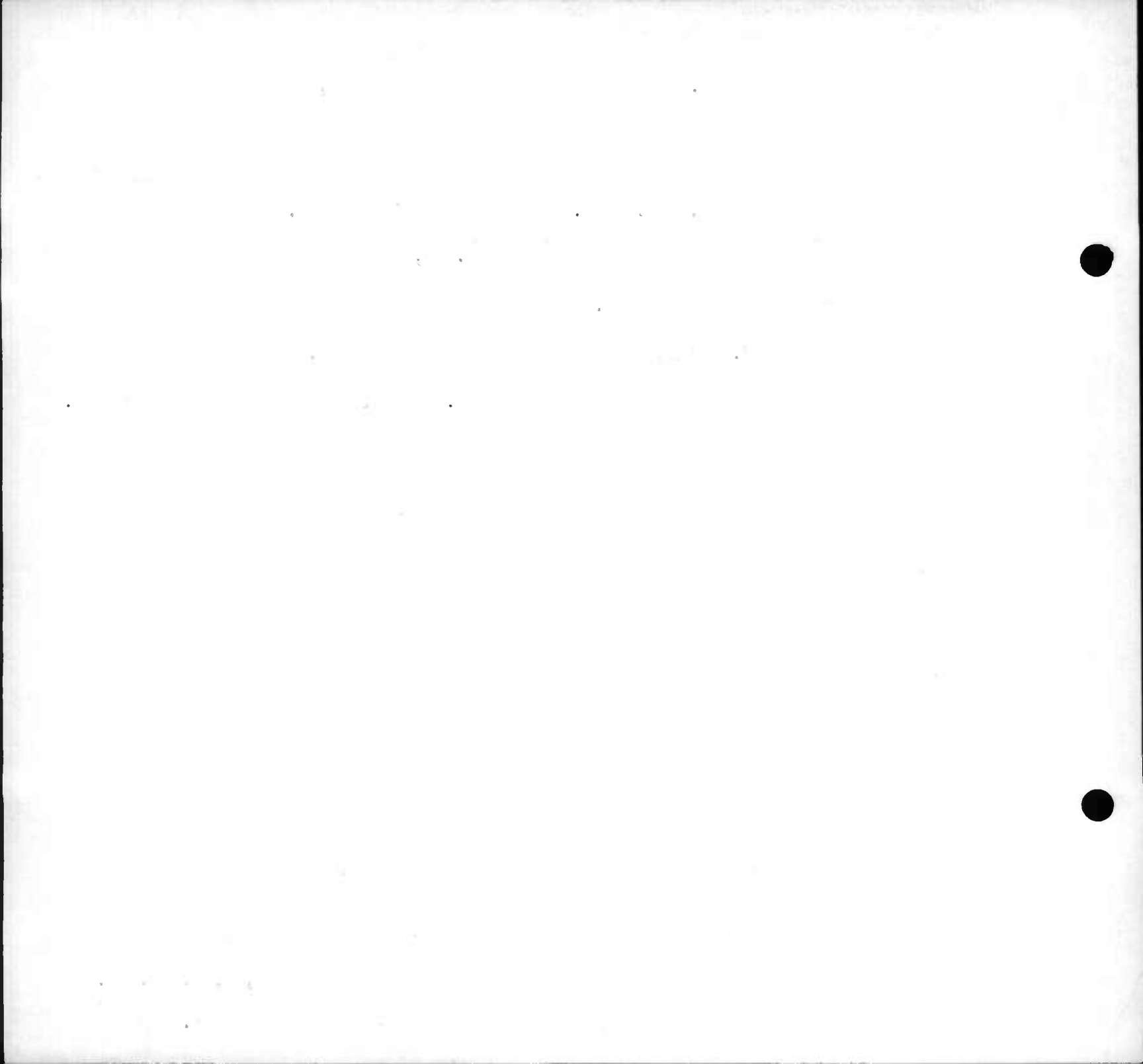
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5525	
BIRTH NO. 67 5525		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William F. Stolzenbach	
2. DATE AND HOUR OF DEATH June 5, 1967 5:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 00		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 437 S. Smallwood St.		E. STREET ADDRESS (If rural, give location) 437 S. Smallwood St.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug. 15, 1889 77
9. AGE (In years last birthday) 77		10. AGE (In years last birthday) 77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		10B. KIND OF BUSINESS OR INDUSTRY Plumbing	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-4681	
17. INFORMANT Blara Stolzenbach		ADDRESS 437 S. Smallwood St.	
18. CAUSE OF DEATH 420.1 I		INTERVAL BETWEEN ONSET AND DEATH immediate	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Coronary thrombosis		(A) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. arteriosclerosis		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Parkinson's Disease		(C) DUE TO	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) 0		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 19 66 to June 5 , 19 67 , that (I) (we) last saw the deceased alive on June 5 , 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE H.H. Baylus		23B. DATE SIGNED 6 June 67	
23C. PHYSICIAN'S NAME (Type) H.H. Baylus		23D. ADDRESS 1600 Wilkens Ave Balto Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/9/67	
24C. NAME OF CEMETERY or CREMATORY Landon Park Cemetery Baltimore Md.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Walter Edward Home Pratt & Stricker		ADDRESS 437 S. Smallwood St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

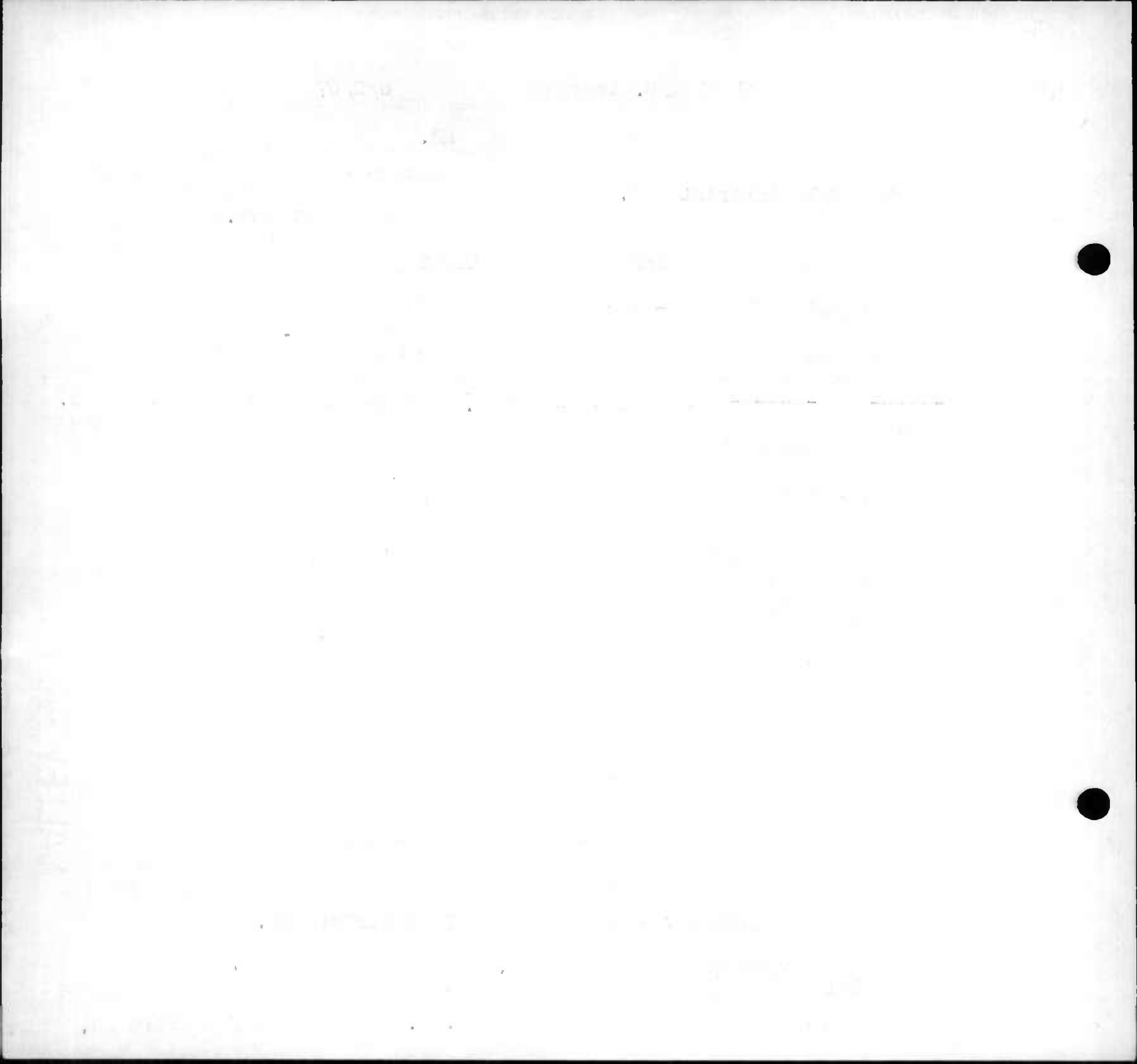
BALTIMORE CITY HEALTH DEPARTMENT									
67 5526 CERTIFICATE OF DEATH					Registered No. 67 5526				
1. NAME OF DECEASED (Type or Print) John A. Meritt					2. DATE AND HOUR OF DEATH June 6, 1967 3:20 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Balto. Gen. Hosp.					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 24-02 D. STREET ADDRESS (If rural, give location) 1435 Boyle St.				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 25, 1925	9. AGE (In years last birthday) 41	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Estimator			10B. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Robert E. Meritt					14. MOTHER'S MAIDEN NAME Delphia E. Propst				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Lois G. Meritt 1435 Boyle St.				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Crownary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Atherosclerosis					INTERVAL BETWEEN ONSET AND DEATH 6 hrs				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Feb 1965 to May 1967 , that (I) (we) last saw the deceased alive on 26 May 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE H. H. Baylous					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7 June 67		
23C. PHYSICIAN'S NAME (Type) H. H. BAYLOUS					23D. ADDRESS 1600 Wilkins Ave Balto, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6 9 1967		24C. NAME OF CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie, A. A. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR 5 30 113		ADDRESS 130 E. Fort Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

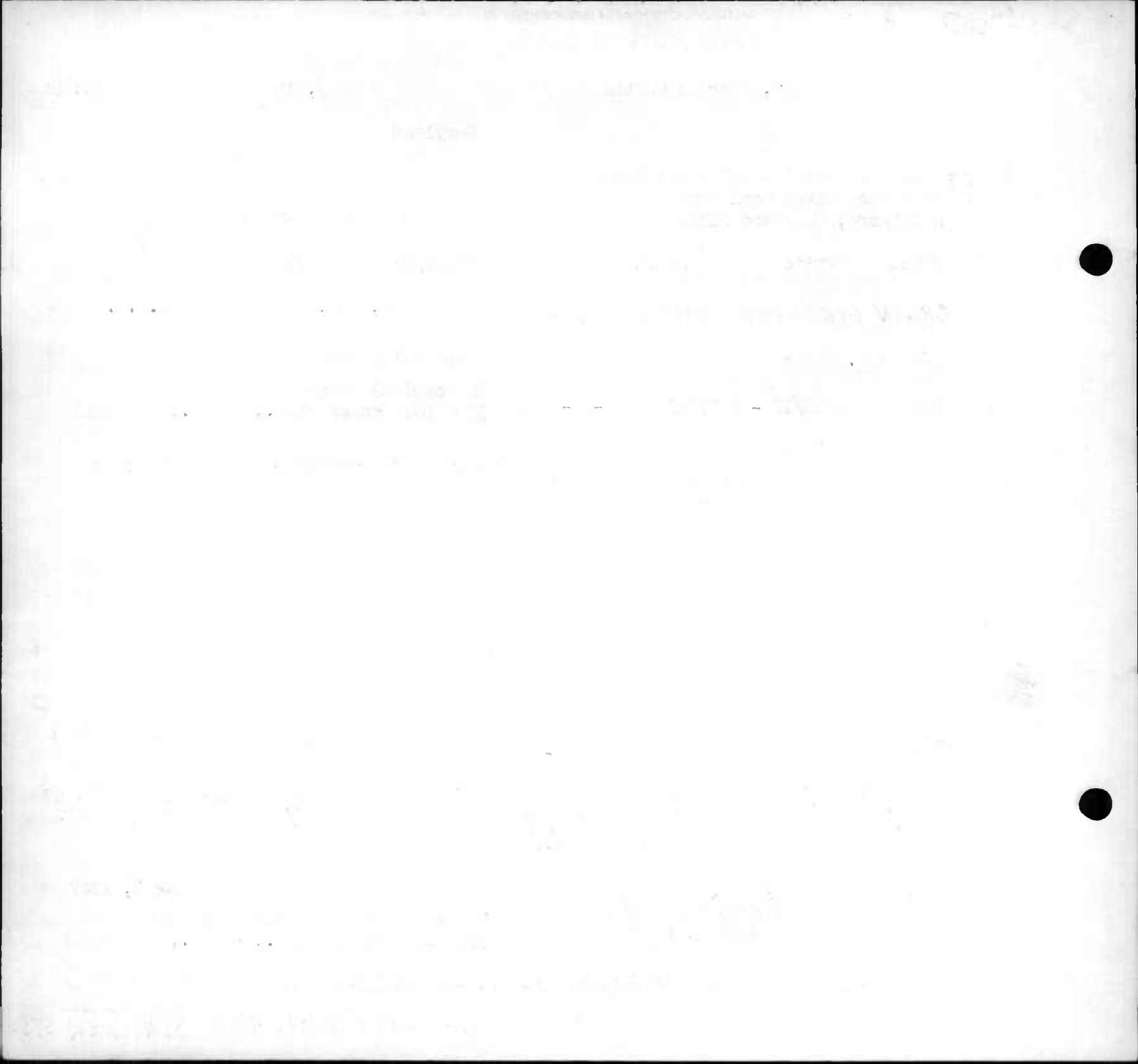
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5527</u>	
BIRTH NO. <u>67 5527</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>William G. Voermann</u>		2. DATE AND HOUR OF DEATH <u>6/2/67</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>00 2915 Oakcrest Ave.</u>		D. STREET ADDRESS (If rural, give location) <u>2915 Oakcrest Ave.</u>		27-07	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>12/20/98</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. <u>215-01-1866</u>		17. INFORMANT ADDRESS <u>Wm. O Voermann 8112 Clyde Bank Rd.</u>	
18. <u>42011 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <u>Anterograde A-V Disease</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary Artery Disease</u>		18B. DUE TO		18C. DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/27</u> 19 <u>67</u> to <u>5/27</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/27</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Nathan Janney</u> M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6/5/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Nathan Janney</u> M.D.		23D. ADDRESS <u>7101 Harford Rd.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/6/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 8 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>P. A. Heemann 6067 Harford Rd.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5528	
BIRTH NO. 67 5528		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SEALS, Charles Martin		2. DATE AND HOUR OF DEATH June 5, 1967 10:45A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 302 South Bruce Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/11/92	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRAIN OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY SHIP BUILDING		11. BIRTHPLACE (State or foreign country) Rossville, Ill.	
13. FATHER'S NAME James L. Seals		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5/10/17 - 1/25/19		16. SOCIAL SECURITY NO. 219-07-8381		17. INFORMANT ADDRESS VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH (A) 10 years DUE TO (B) _____ DUE TO (C) _____			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 5th 19 67 to June 5th 19 67 , that (I) (we) last saw the deceased alive on June 5th 19 67 and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Margaret A. Dennis MARGARET A. DENNIS				23B. DATE SIGNED June 6, 1967	
23C. PHYSICIAN'S NAME (Type) MARGARET A. DENNIS		23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Blvd., Balto., Md 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-8-67		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL CEM. BALTIMORE-MARYLAND	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR Charles E. Johnson		25C. FUNERAL DIRECTOR ADDRESS WALTERS FUNERAL HOME PRATT & STRICKER STS.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5529	
BIRTH NO. 67 5529		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BEVANS, LLOYD E.		2. DATE AND HOUR OF DEATH 6-6-67 2:45A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21230 24-03 D. STREET ADDRESS (If rural, give location) 1431 WILLIAMS STREET			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-14-96	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY POLICE DEPARTMENT		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ELMER BEVANS			
14. MOTHER'S MAIDEN NAME MARY POTTER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 213281715		17. INFORMANT ADDRESS ST. AGNES RECORDS - CATON & WILKENS AVE 21229			
18. 15331 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Polycystic Metastatic Carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Polycystic Metastatic Carcinoma DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH About 1 year			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5-22-1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA - sigmoid		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 13 1967 to JUNE 6 1967 that (I) (we) last saw the deceased alive on JUNE 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carl H. Matthey				23B. DATE SIGNED 6-6-1967	
23C. PHYSICIAN'S NAME (Type) CARL H. MATTHEY				23D. ADDRESS ST. AGNES HOSPITAL-CATON & WILKENS AVE 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6 9 67		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) Brooklyn, A. A. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Mc Cully		ADDRESS 130 E. Fort Ave	

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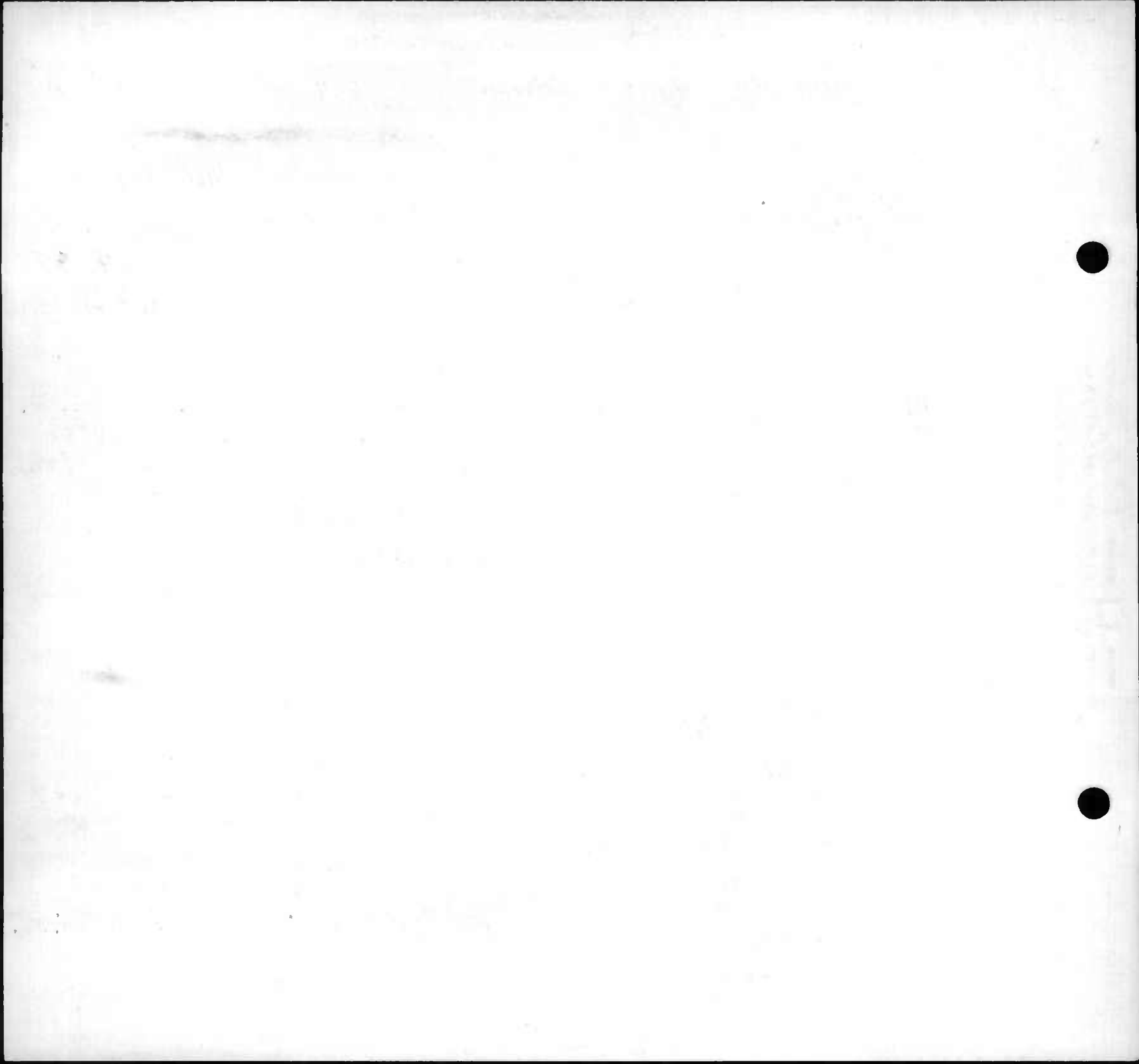
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

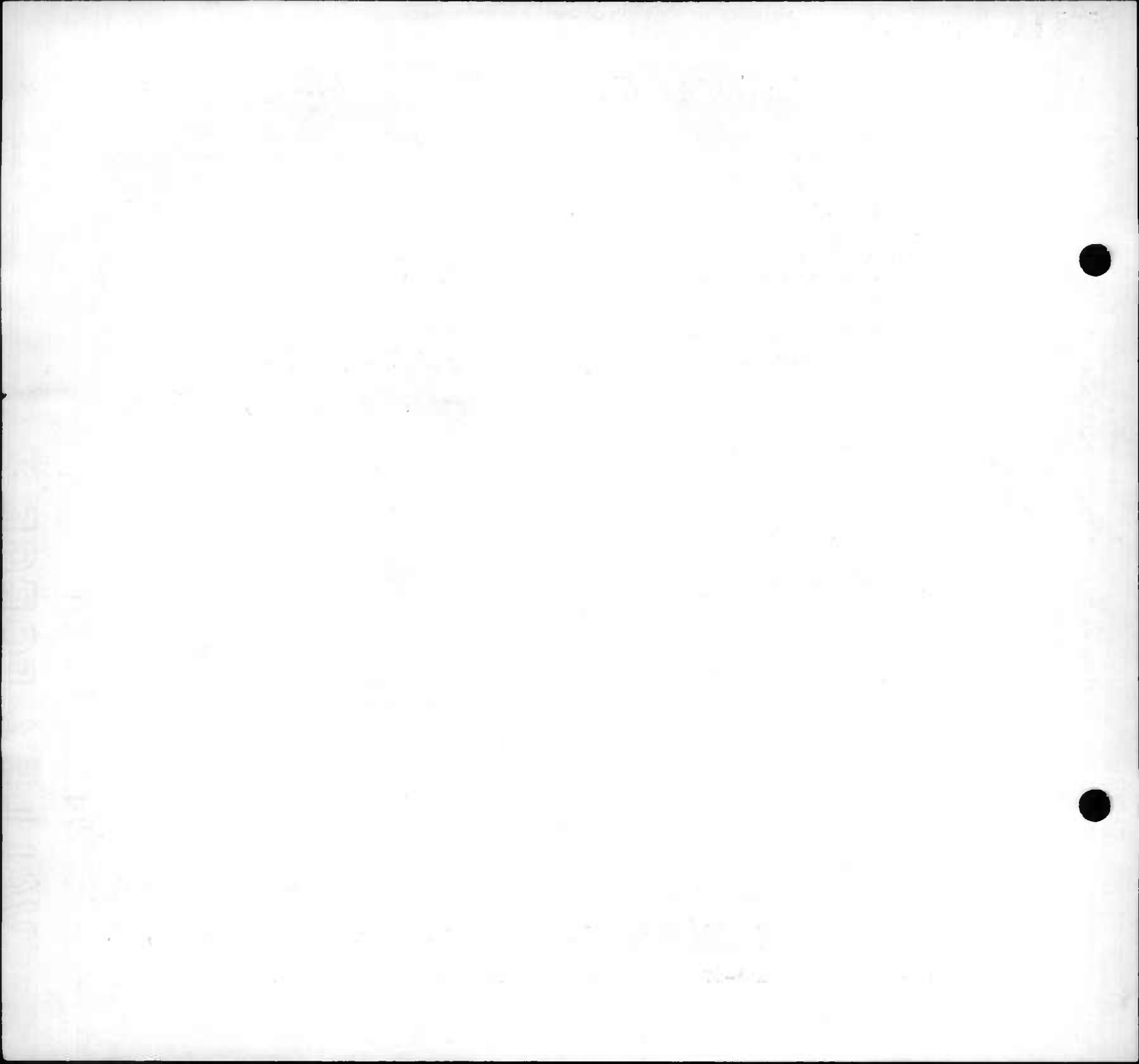
BIRTH NO. 5-120 27-10628		67 5530		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5530	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BABY BOY SHIRLEY SAVAGE				2. DATE AND HOUR OF DEATH 6-4-67 4 ¹⁰ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224				A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Md. 21223 D. STREET ADDRESS (If rural, give location) 413 N. Gilmore Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 6-3-67	9. AGE (In years last birthday) 4 1/2 yrs	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Shirley			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT BCH: Records 4940 Eastern Ave. Baltimore, Md. # 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) ANPEA (B) UNEXPANDED LUNGS (C) PREMATUREITY				INTERVAL BETWEEN ONSET AND DEATH 4 hrs 47 min			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		21C. WHERE DID INJURY OCCUR? NO		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) NO		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-3 19 67 to 6-4 19 67, that (I) (we) last saw the deceased alive on 6-4 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. McHugh				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> HOUSE Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-4-67	
23C. PHYSICIAN'S NAME (Type) E. McHugh				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Balto., Md. BOX 93, JOHNS HOPKINS HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 6-6-67		24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224	
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR R. E. E. F. F.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

4-163		67 5531		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5531		4	
BIRTH NO. 67-10636		M.E. CASE NO.		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) HUBBARD, BABY				2. DATE AND HOUR OF DEATH 6/2/67 9:30 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS BCH 4940 EASTERN AVENUE BALTIMORE, MD. #21224				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2632 KIRK AVENUE #21218					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 6/2/67	9. AGE (In years last birthday) NB.	If Under 1 Yr. Months Days 4 0		If Under 24 Hrs. Hours Min. 4 0	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Hubbard, Carolyn					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S NAME AND ADDRESS RECORDS: BCH 4940 Eastern Avenue Baltimore, Maryland #21224					
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) Prematurity - non viable 9 1/2 mo. gestation (B) _____ (C) _____				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 2 19 67 to June 2 19 67 , that (I) (we) lost saw the deceased alive on June 2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. YECIES				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/2/67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS J. YECIES M.D. 4940 Eastern Avenue Baltimore, Md. #21224							
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 6-6-67		24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224			
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

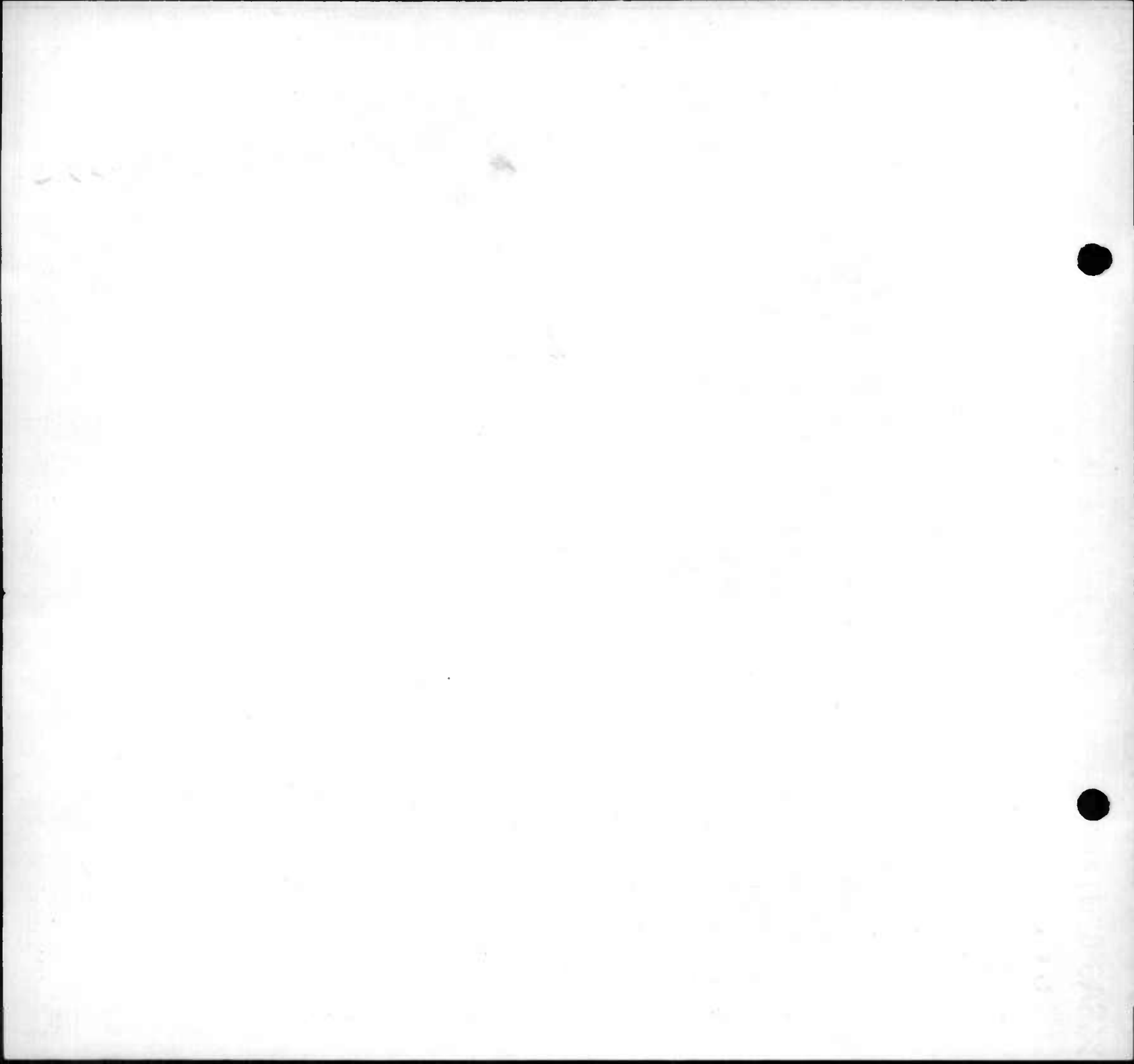
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5532</u>	
BIRTH NO. <u>67 5532</u>				M.E. CASE NO. <u>67-08923</u>	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
<u>Baby Boy Stafford</u>			<u>5/12/67 15:15 A.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital of Baltimore</u>			A. STATE <u>Maryland</u> B. COUNTY <u>-</u>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			D. STREET ADDRESS (If rural, give location) <u>830 Argonne Drive, Apt 2</u>		
5. SEX <u>m</u>		6. RACE <u>w</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>never married</u>	
8. DATE OF BIRTH <u>5/9/67</u>		9. AGE (In years last birthday) <u>0 2</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>James Stafford</u>			14. MOTHER'S MAIDEN NAME <u>Lana Balshaw</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>226X1</u>			CAUSE OF DEATH (A) <u>Immaturity (BW-86ogr)</u> (B) <u>-</u> (C) <u>-</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>II</u>			INTERVAL BETWEEN ONSET AND DEATH <u>55 hrs.</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>0</u>					
19A. DATE OF OPERATION <u>0 0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>May 9</u> 19 <u>67</u> to <u>May 12</u> 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>May 12</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Allan J. Monfried</u>				23B. DATE SIGNED <u>5/12/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Allan J. Monfried</u>				23D. ADDRESS <u>Sinai Hospital of Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>6-667</u>		24B. DATE <u>6-667</u>		24C. NAME OF CEMETERY or CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>	
24D. LOCATION (City, town or county) <u>Baltimore</u>		24E. STATE <u>MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 8 1967</u>		25B. NAME OF REGISTRAR <u>ROBERT E. FADYNE</u>		25C. FUNERAL DIRECTOR <u>51 MORTUARY SERVICE - BCHD</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

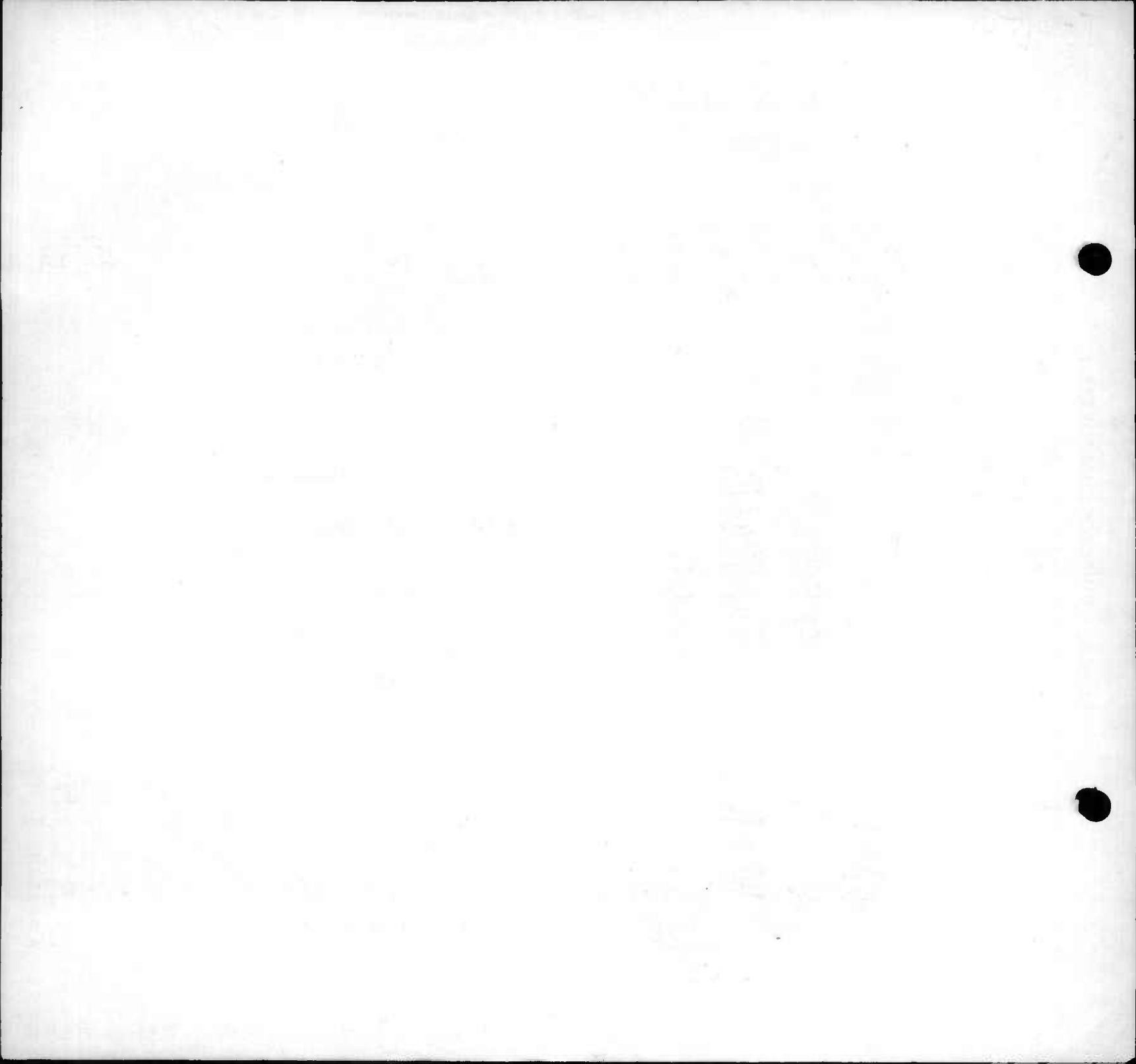
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 5533		CERTIFICATE OF DEATH		67 5533	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MABEL SMITH		2. DATE AND HOUR OF DEATH 6-4-67 10³⁵ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY MD. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Md. 11-02 D. STREET ADDRESS (If rural, give location)			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 6-10-96	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Wm Smith		14. MOTHER'S MAIDEN NAME Cecilia J. Hart			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Bilateral pneumonia		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of esophagus 2 wks		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/31/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Esophagus carcinoma		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/5/67 19 67 to 6/4/67 19 67 , that (I) (we) last saw the deceased alive on 6/4/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Narong Ruangruchira M.D.				23B. DATE SIGNED 6/6/67	
23C. PHYSICIAN'S NAME (Type) NARONG RUANGRUCHIRA		23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6-6-67		24C. NAME OF CEMETERY or CREMATORY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5534				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5534	
M.E. CASE NO. 67-10418				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BARBY Boy TYSON				2. DATE AND HOUR OF DEATH 5-31-67 7:00 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital of Balto, Inc.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4007 Aragon Ave. (15)			
5. SEX ♂	6. RACE N N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 5-30	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David Tyson				14. MOTHER'S MAIDEN NAME Totten			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 770.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Distress ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Maximal Asphyxia				CAUSE OF DEATH (A) Respiratory Distress DUE TO (B) Maximal Asphyxia DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH 6 hrs 22 min							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-31-1967 to 5-31-1967 , that (I) (we) last saw the deceased alive on 5-31-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stephen Gordon M.D.				23B. DATE SIGNED 5-31-67			
23C. PHYSICIAN'S NAME (Type) Stephen Gordon				23D. ADDRESS Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6-6-67		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR 551 MORTUARY SERVICE - BCHD			



FUNERAL DIRECTOR: IMPORTANT

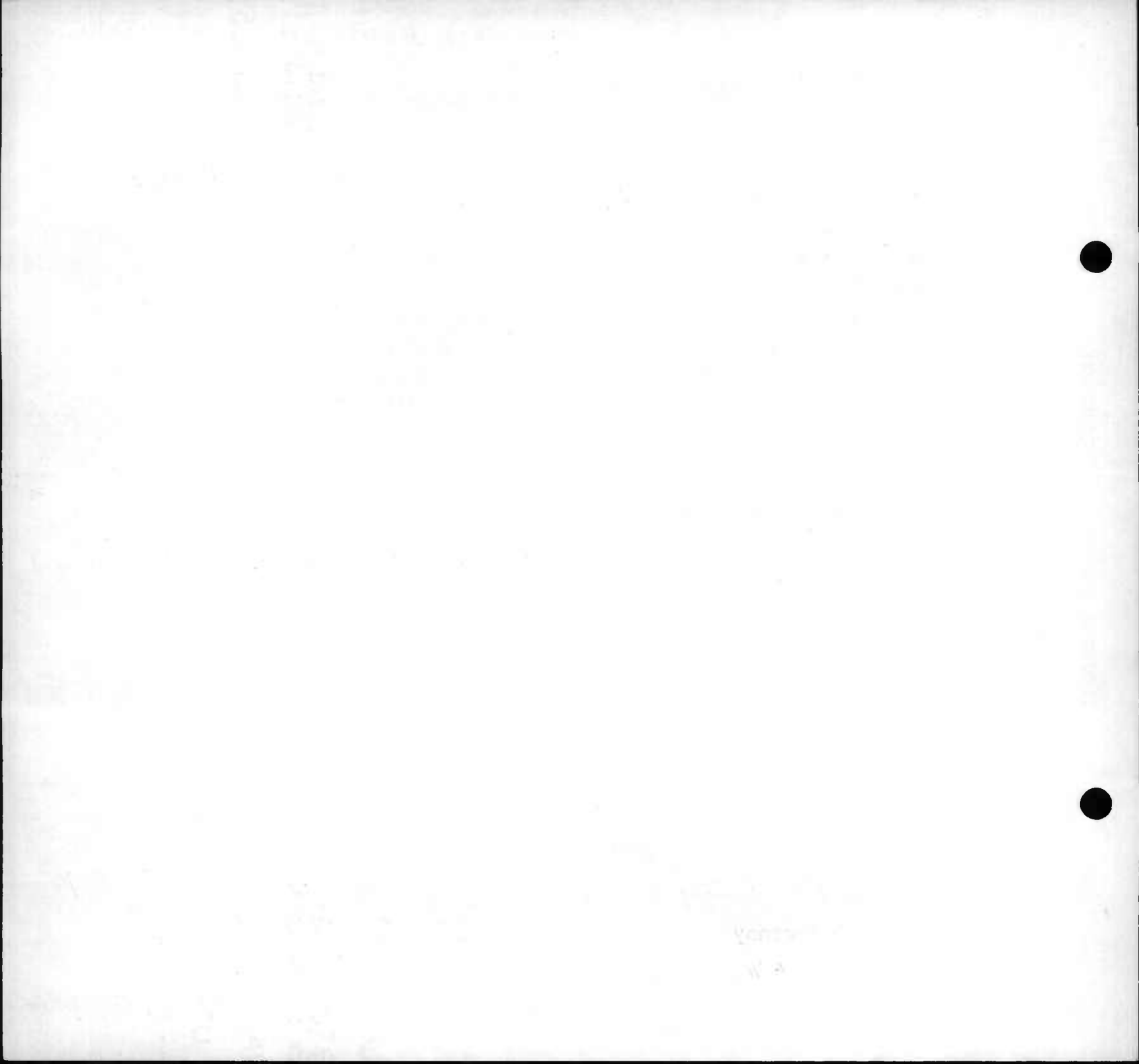
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>Pr Geo. & Md. 67</i> 5535		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <i>67</i> 5535	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Lionel Bradley</i>		2. DATE AND HOUR OF DEATH <i>6/3/67</i> <i>10</i> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>The Johns Hopkins Hospital</i> <i>33</i>		4. USUAL RESIDENCE (Where deceased lived; If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Prince George Co.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Deanwood Park Md. 20027</i> D. STREET ADDRESS (If rural, give location) <i>5110 Nash St. N.E. 66-00</i>			
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never married</i>	8. DATE OF BIRTH <i>4/19/67</i>	9. AGE (In years lost birthday) <i>1</i> <i>16</i>	If Under 1 Yr. Months: Days: Hours: Min. <i>1</i> <i>16</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
13. FATHER'S NAME <i>Lawrence R. Bradley</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Hiers</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>754-51</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cardiac Arrhythmia</i> DUE TO <i>? Heart block (bradycardia)</i> (B) <i>Congenital Cardiac Disease</i> DUE TO <i>(VSD + ? other anomaly)</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>4 1/2 hrs.</i> <i>6 wks</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Cardiac catheterization immediately preceding cardiac arrhythmia</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/2/67</i> 19 <i>67</i> to <i>6/3</i> 19 <i>67</i> , that (I) (we) test saw the deceased alive on <i>6/3</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John D. Johnson</i>		M.D. <i>House Staff - Asst. Resident</i>		23B. DATE SIGNED <i>6/4/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOHN D. JOHNSON</i>		23D. ADDRESS <i>The Johns Hopkins Hospital - Pediatrics</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>CREMATION</i>		24B. DATE <i>6-5-67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>JOHNS HOPKINS HOSP.</i>	
24D. LOCATION (City, town, or county) <i>BALTIMORE MD.</i>		24E. NAME OF REGISTRAR <i>Dr. B. E. F. M.D.</i>		24F. FUNERAL DIRECTOR <i>55</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 8 1967</i>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <i>HOSPITAL DISPOSAL</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

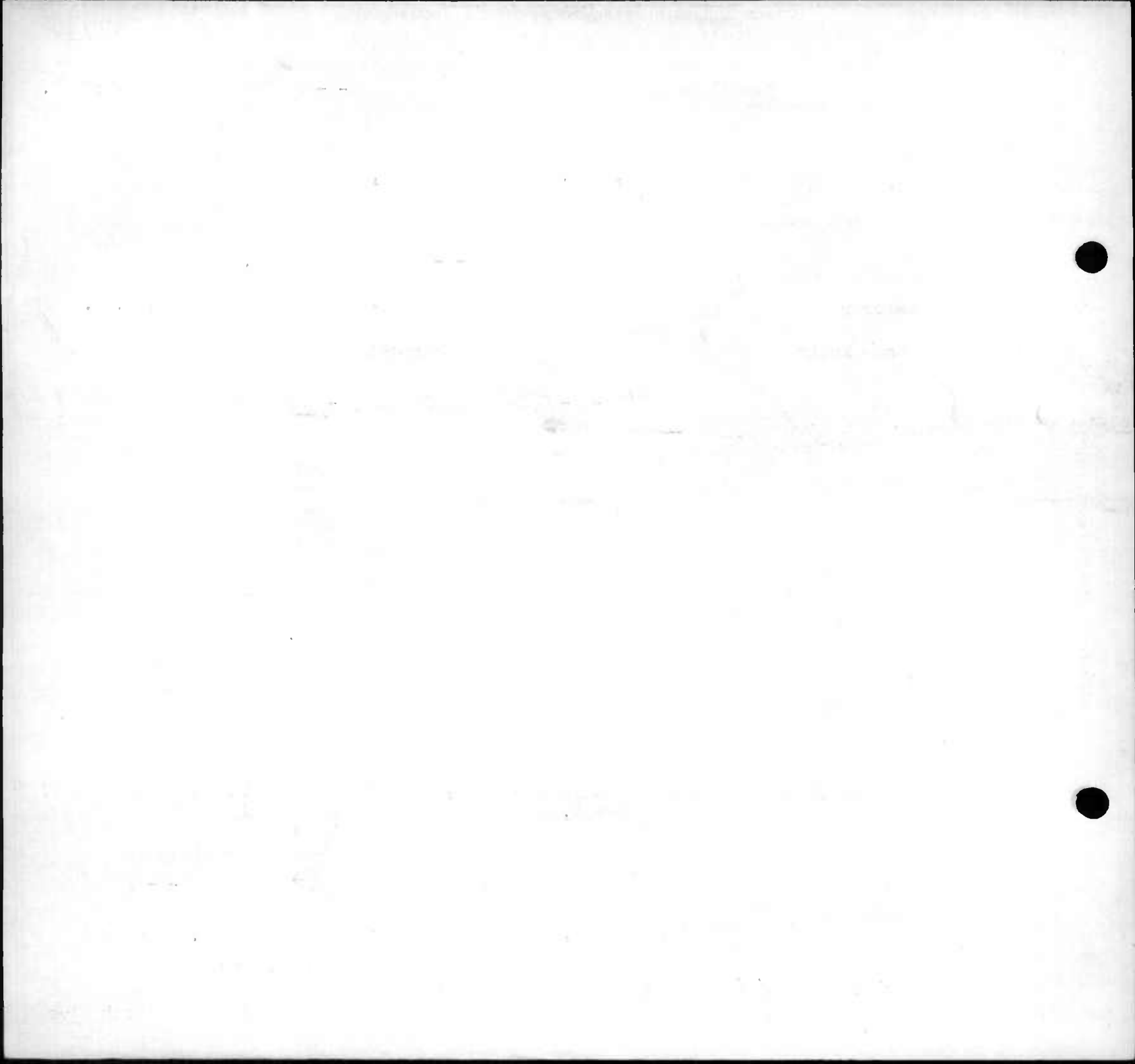
BIRTH NO. 67 5536		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5536	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BRADSHAW, CHARLOTTE		2. DATE AND HOUR OF DEATH 6-7-67 10 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSP		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MD 18-03			
		D. STREET ADDRESS (If rural, give location) 114 Scott St			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 7-20-27	9. AGE (In years last birthday) 39	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROL	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME FRED HARRIS		14. MOTHER'S MAIDEN NAME NANNIE EDMUNDS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT William A Bradshaw	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 581.0 I CAUSE OF DEATH (A) CIRRHOSIS of LIVER (B) PNEUMONIA- (C) ASPIRATION = CARDIAC ARREST		INTERVAL BETWEEN ONSET AND DEATH 2+ years 10 days 5 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION TRACHEOSTOMY		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 6-5-67		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-31-1967 to 6-7-1967, that (I) (we) lost saw the deceased alive on 6-7-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B Portnoy		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-7-67	
23C. PHYSICIAN'S NAME (Type) B Portnoy		23D. ADDRESS M.D. UNIVERSITY HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/11/67		24C. NAME OF CEMETERY OR CREMATORY Harrison	
24D. LOCATION (City, town, or county) (State) Littleton N.C.					
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles A. Rice	
25D. ADDRESS 661 W. Borne St					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5537					Registered No. 67 5537				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Samuel Kelly					2. DATE AND HOUR OF DEATH 6-4-67 EOR 1:26 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, 16-08				
D. STREET ADDRESS (If rural, give location) 709 North Edgewood Street									
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6-9-1895	9. AGE (in years last birthday) 70 yrs.	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Sam Kelly					14. MOTHER'S MAIDEN NAME Margaret				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 249-05-4052-A		17. INFORMANT Fannie Kelly - daughter		ADDRESS SAME		
18. 151 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma of stomach with metastasis to the Liver					CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH ?		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO				
					(B) DUE TO				
					(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 6			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from June 4, 1967 to June 4, 1967 , that (I) (we) last saw the deceased alive on June 4, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE William Johnson					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-5-67		
23C. PHYSICIAN'S NAME (Type) William Johnson,					23D. ADDRESS 1514 Division Street Balto., Maryland				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/8/67		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md			
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967			25B. NAME OF REGISTRAR Adolphus Malstead			25C. FUNERAL DIRECTOR Adolphus Malstead 1206 W North Ave			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

TANYA

SMITH

2. DATE AND HOUR PRONOUNCED DEAD

June 5, 1967

8:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1032 E. Pratt Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Child

8. DATE OF BIRTH

9. AGE (In years
last birthday)

2 1/2

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Child

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Maryland

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Norman Smith

14. MOTHER'S MAIDEN NAME

Betty Jean

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Cornelia Roberts,

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Sickle Cell Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/6/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/9/67

23C. NAME of CEMETERY or CREMATORY

Clifton Park

23D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUN 8 1967

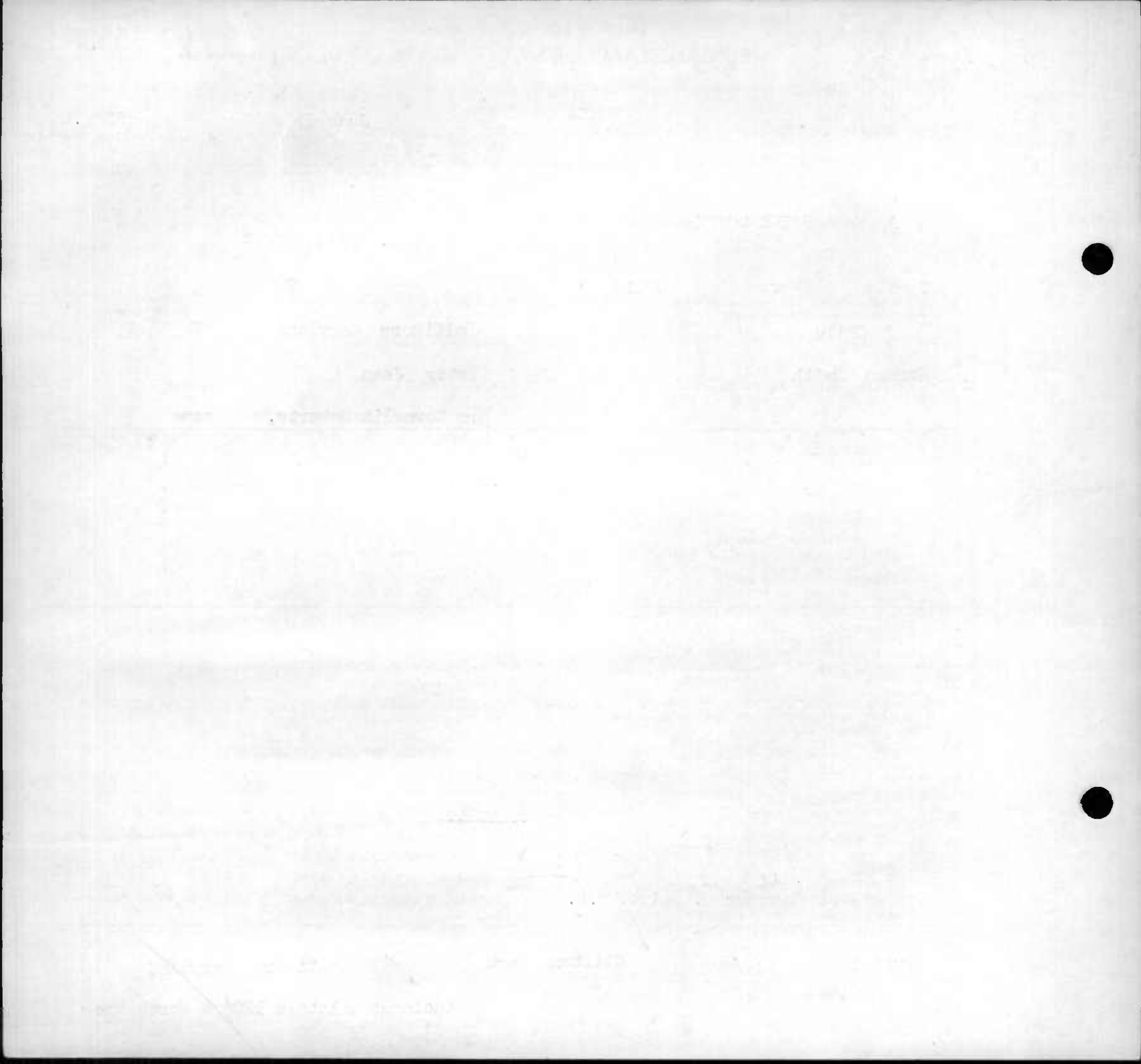
24B. NAME OF REGISTRAR

Robert E. Parker, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

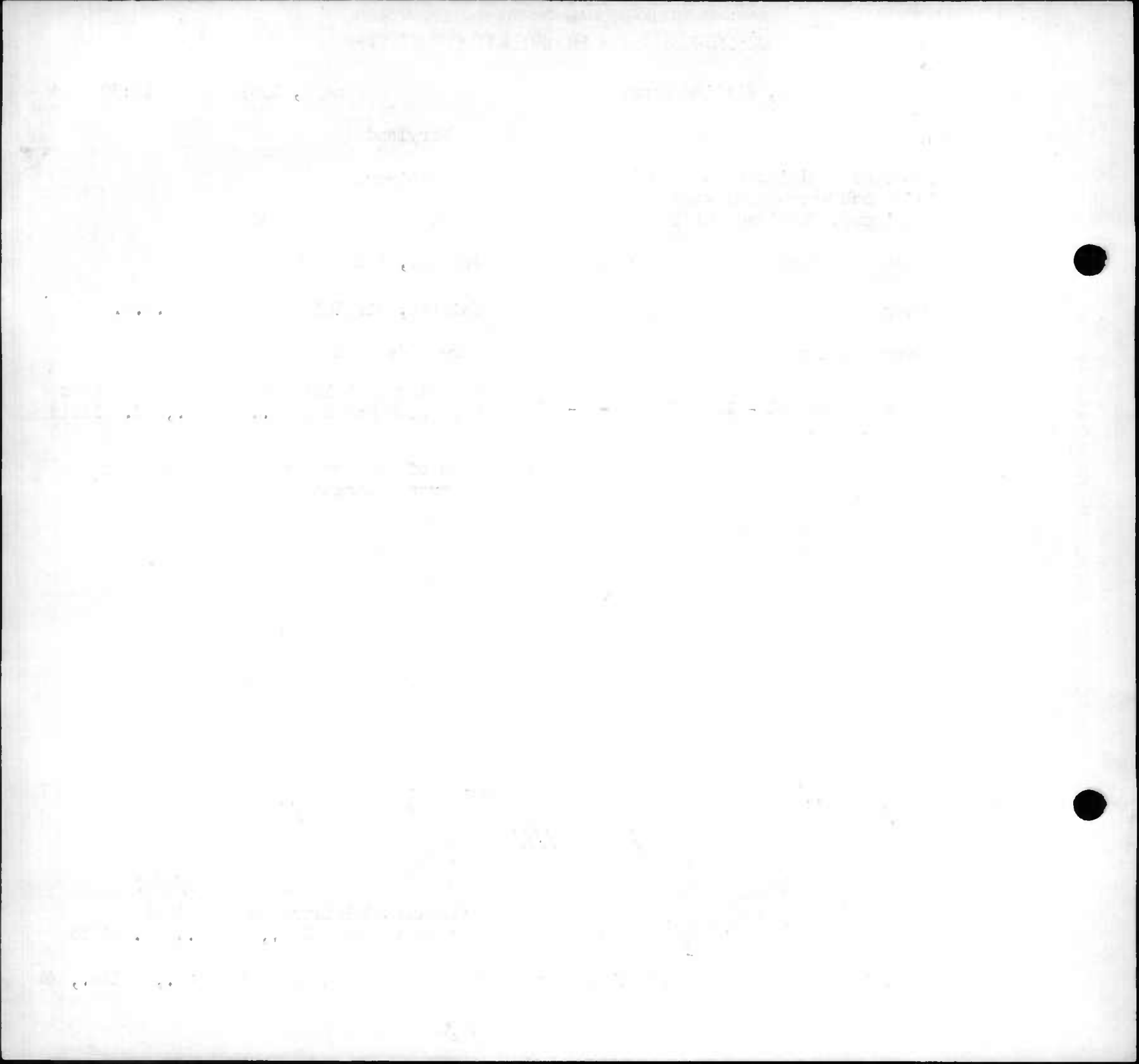
Adolphus Halstead 1206 W North Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

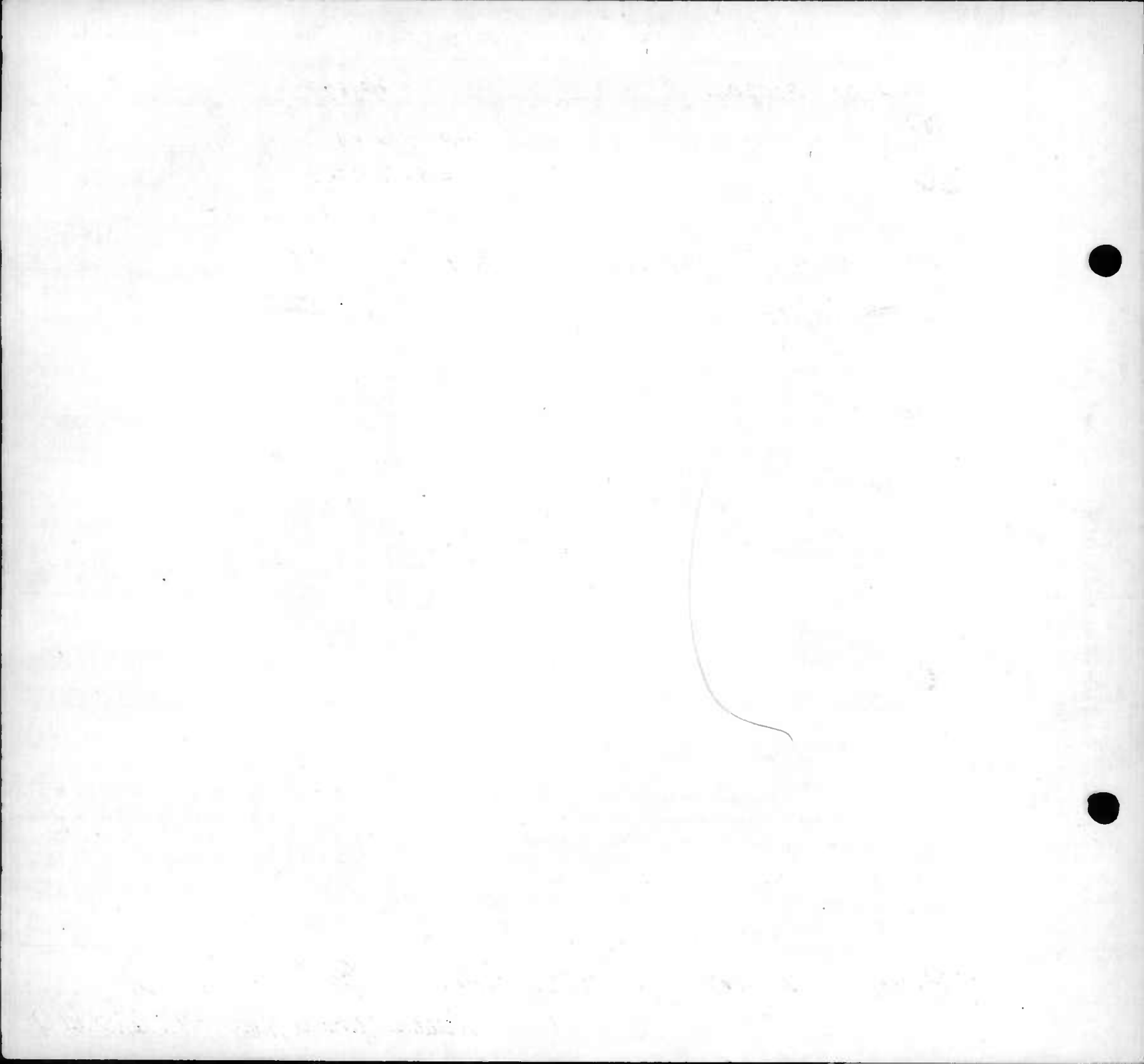
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5539</u>	
BIRTH NO. <u>67 5539</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>STYLES, William Henry</u>			
2. DATE AND HOUR OF DEATH <u>June 5, 1967</u> <u>10:30</u> A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-47</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3306 Windsor Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>June 13, 1919</u>	9. AGE (In years last birthday) <u>47</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Hospitals</u>		11. BIRTHPLACE (State or foreign country) <u>Fairfax, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Jerry Styles</u>			14. MOTHER'S MAIDEN NAME <u>Irene Jackson</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>5/20/41 - 10/20/45</u>		16. SOCIAL SECURITY NO. <u>217-26-0337</u>		17. INFORMANT ADDRESS <u>Veterans Administration Hospital Records</u> <u>3900 Loch Raven Blvd., Balto., Md. 21218</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>15-18-1</u> (A) <u>Carcinoma of stomach with widespread metastases</u> DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>W</u> (this hospital) attended the deceased from <u>April 25th</u> 19 <u>67</u> to <u>June 5th</u> 19 <u>67</u> , that <u>W</u> (we) last saw the deceased alive on <u>June 5th</u> 19 <u>67</u> and that in <u>W</u> (our) opinion death occurred on the date and hour and from the causes stated above. (<u>W</u> (We) (did) <u>W</u> view the body after death.					
23A. SIGNATURE <u>[Signature]</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>6/7/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>ERNESTO SMITH</u>		23D. ADDRESS <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Blvd., Balto., Md. 21218</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>June 8 1967</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
24D. LOCATION (City, town, or county) (State) <u>5501 Frederick Ave., Balto., Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 8 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Morton E. Dyett F.H. 1701 LAURENS</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5540</u>	
BIRTH NO. <u>67 5540</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>EDWARD BOULON</u>			6/2/67 10 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>FRANKLIN SQUARE HOSPITAL</u>			A. STATE <u>Maryland</u> B. COUNTY <u>18-02</u>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		
			D. STREET ADDRESS (If rural, give location) <u>27 N. Carey St.</u>		
5. SEX <u>M</u>	6. RACE <u>Nonwhite</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>3/19/84</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>tailor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>La.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 56 6814 J1</u>	17. INFORMANT <u>CHART</u>		
18. <u>334X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized Arteriosclerosis - years</u> <u>Cerebro-vascular Insufficiency - years</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/26</u> 19 <u>67</u> to <u>6/2</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/2</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE <u>R. M. Magno</u>				23B. DATE SIGNED <u>6/2/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>RAYMUNDO S. MAGNO M.D.</u>				23D. ADDRESS <u>FRANKLIN SQUARE HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/8/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>W. Calvary Cem.</u>	
24D. LOCATION (City, town or county) (State) <u>Cedar Hill Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 8 1967</u>		25B. NAME OF REGISTRAR <u>R. E. S. F. D. Jr.</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home 319 N. Schroeder St.</u>	

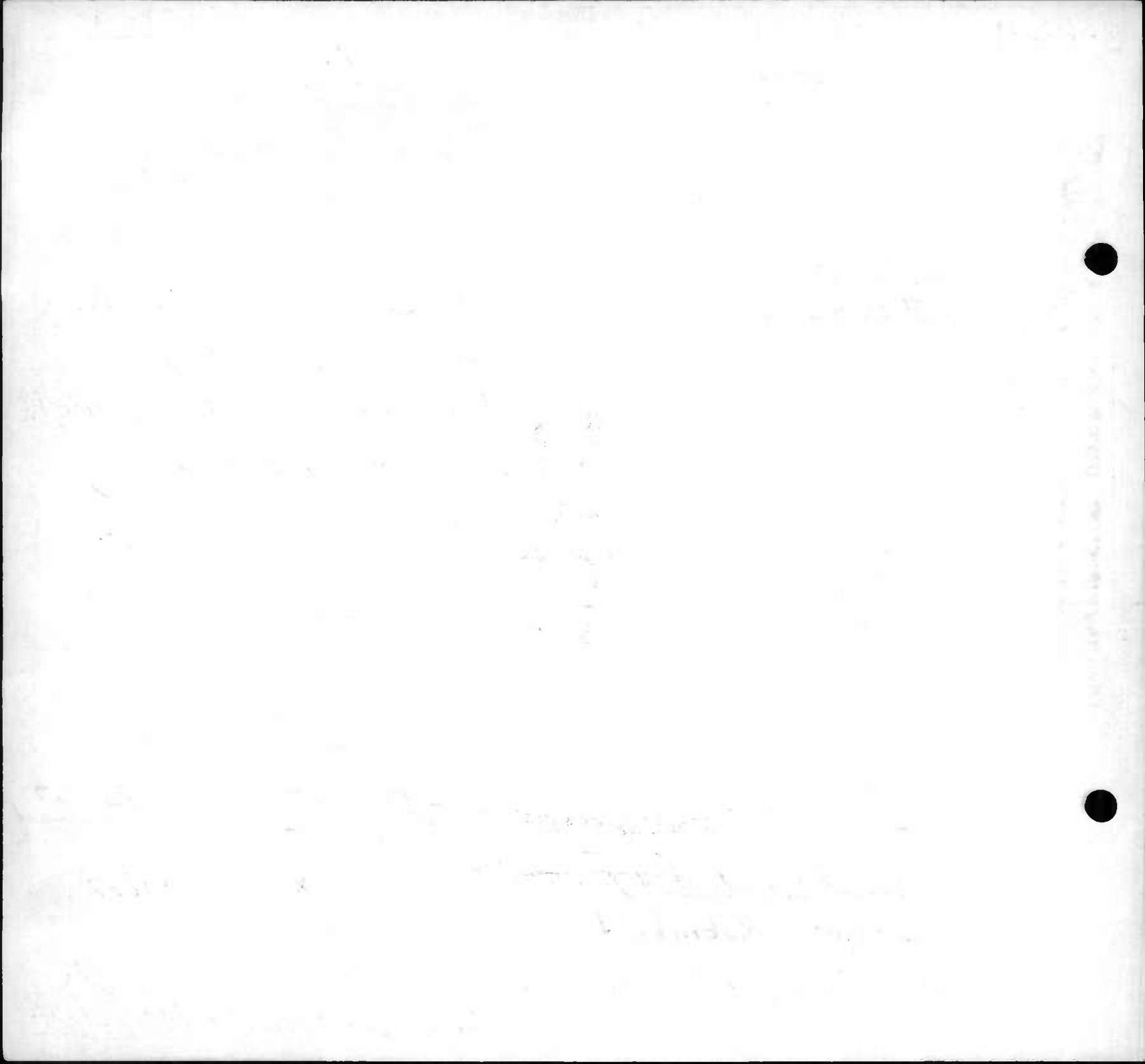


Approved: _____

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5541		BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 67 5541	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Benny Benjamin Brown		2. DATE AND HOUR OF DEATH 6-6-67			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Loch Raven V.A. Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 8. COUNTY A.A. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Davidsonville D. STREET ADDRESS (If rural, give location) 32-00			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED Married	8. DATE OF BIRTH 3-17-14	9. AGE (In years lost birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Benjamin Brown		14. MOTHER'S MAIDEN NAME Irene BROWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Chene Brown Davidsonville	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Restrictive lung disease Empyema several weeks.		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/25 19 67 to 6/6 19 67 , that (I) (we) last saw the deceased alive on 6/5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel G. Robinhold		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/7/67	
23C. PHYSICIAN'S NAME (Type) Daniel G. Robinhold		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 6-9-67		24B. DATE 6-9-67		24C. NAME OF CEMETERY OR CREMATORY Brewer Hill	
24D. LOCATION (City, town, or county) Annapolis Md.		24E. LOCATION (City, town, or county) Annapolis Md.		24F. LOCATION (City, town, or county) Annapolis Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR William Rees	
25D. ADDRESS Annapolis Md.					



1
5-36367 5542
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5542

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES

STEWART

2. DATE AND HOUR PRONOUNCED DEAD

June 6, 1967

12:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

44 UNION MEMORIAL HOS PITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

411 21½ Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

10/23/27

9. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Laborer

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

James H Stewart

14. MOTHER'S MAIDEN NAME

Margaret Wallace

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

2-Korea

16. SOCIAL
SECURITY NO.

216-24-0035

17. INFORMANT

Family

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Massive Spontaneous Intracerebral

(A) XXXX Hemorrhage

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

6/6/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

May 12/67

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 8 1967

Robert E. Fisk

Robert E. Williams

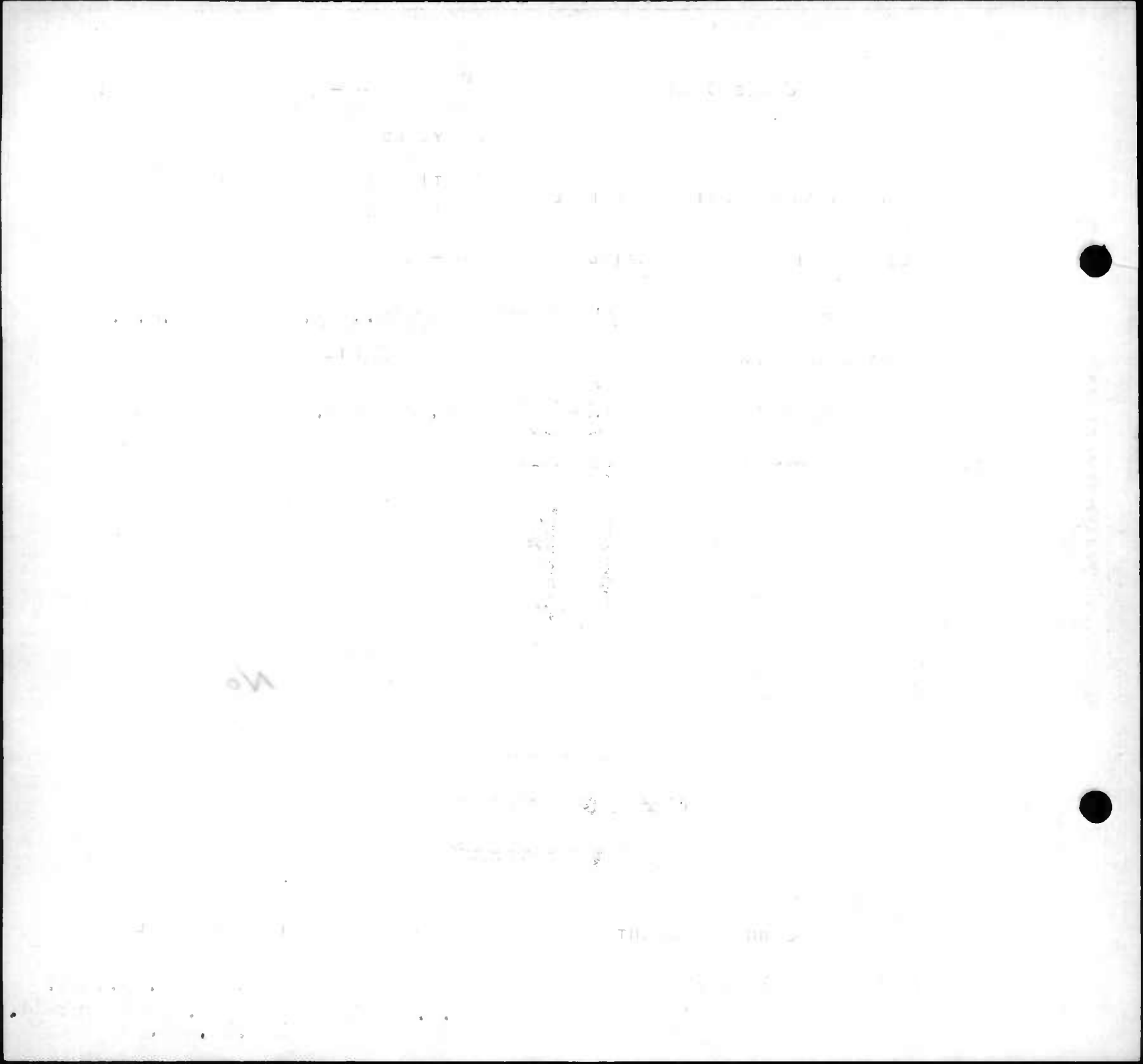
1701 3 N. Bond St. #13

Approved:

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

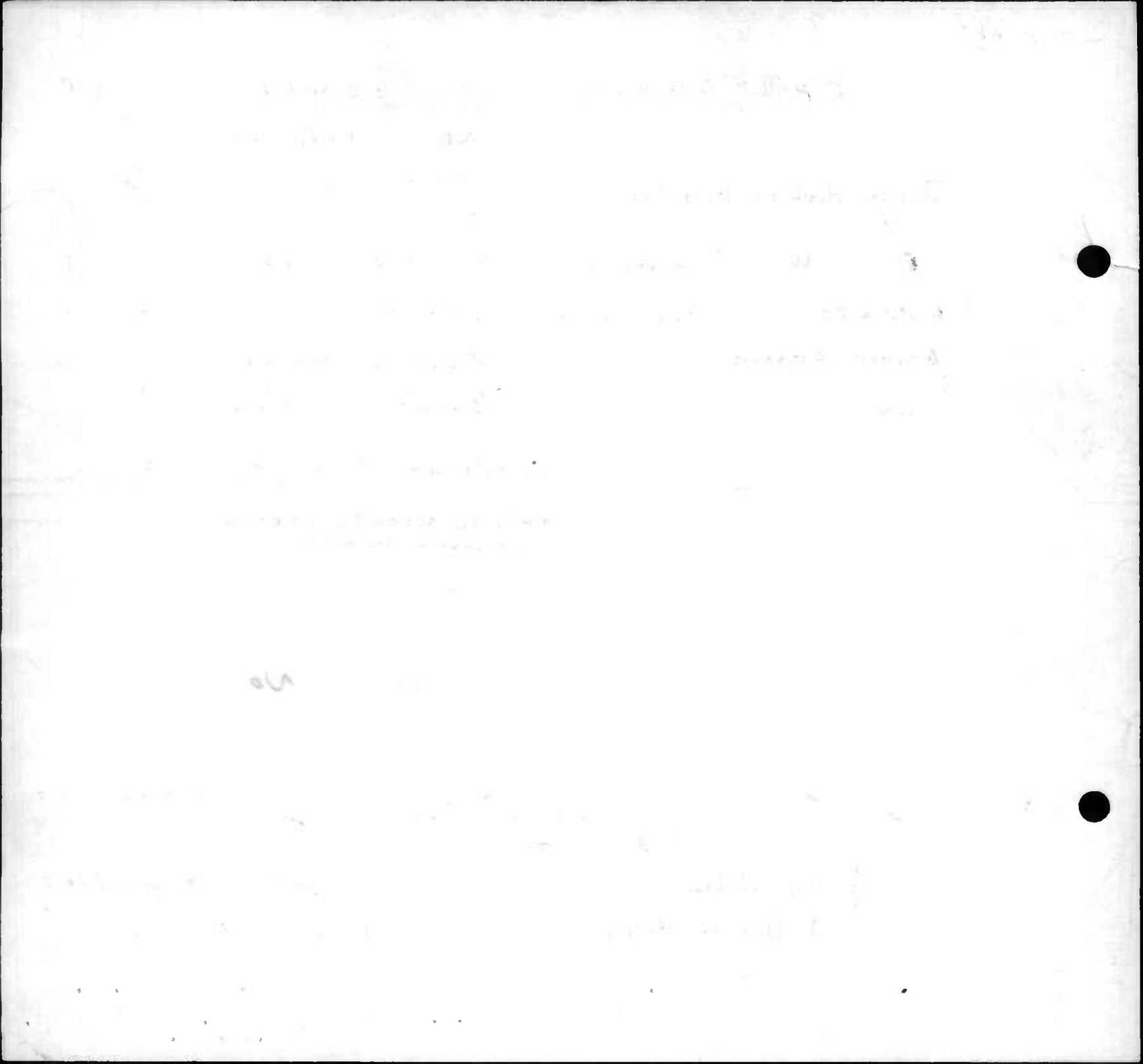
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5543	
BIRTH NO. 67 5543				CERTIFICATE OF DEATH	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) JAMES CARR			6-6-67 7:50PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4611 YORK RD		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-8-04	9. AGE (In years lost birthday) 62	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10B. KIND OF BUSINESS OR INDUSTRY Sweeney's Lounge		11. BIRTHPLACE (State or foreign country) Phila., Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALEXANDER CARR			
14. MOTHER'S MAIDEN NAME XXXXX Sarah Levin		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 217-01-5093A		17. INFORMANT Mrs. Martha M. Carr (Same)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) DUE TO Hepatic insufficiency		19. CAUSE OF DEATH DUE TO G.I. bleeding			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		21. INTERVAL BETWEEN ONSET AND DEATH			
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		23. MEDICAL CERTIFICATION			
24. DATE OF OPERATION 2		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) Yes	
27. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		28. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		30. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg, etc.)		31. WHERE DID INJURY OCCUR?	
32. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		33. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		34. HOW DID INJURY OCCUR?	
35. I certify that (I) (this hospital) attended the deceased from 4/20 1967 to 6/6 1967, that (I) (we) last saw the deceased alive on 6/6/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
36. SIGNATURE John Sargent				37. DATE SIGNED 6/6/67	
38. PHYSICIAN'S NAME (Type) JOHN SERGENT				39. ADDRESS THE JOHNS HOPKINS HOSPITAL	
40. BURIAL CREMATION, REMOVAL (Specify) Burial		41. DATE 6/10/1967		42. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
43. LOCATION (City, town, or county) (State) Parkville, Balto., Co., Md.		44. DATE REC'D BY HEALTH DEPT. JUN 8 1967			
45. NAME OF REGISTRAR Robert E. Taylor		46. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death. Such deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
C-651					67 5544		BIRTH NO.		
M.E. CASE NO.					67 5544		Registered No.		
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
ETHEL G. CRIMMINS					6 June 67 1 P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
JOHN HOPKINS HOSPITAL					MD. BALTIMORE Co.				
5. SEX F					6. RACE W				
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)					8. DATE OF BIRTH				
WIDOWED					31 Jan 1901				
9. AGE (In years last birthday)					10. CITIZEN OF WHAT COUNTRY?				
66					USA				
11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
IRELAND					USA				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
ARTHUR CHANCE					ELIEN MURPHY				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
NO					17. INFORMANT ADDRESS				
					MRS. H.R. FENWICK - BUTLER, MD. CHART - JH				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) CEREBRAL HEMORRHAGE				
ANTECEDENT CAUSES					(B) ARTERIO SCLEROTIC CEREBRAL				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					DUE TO VASCULAR DISEASE				
II					(C)				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
YES					NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED				
(APPROX.)					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (this hospital) attended the deceased from 5 June 1967 to 6 June 1967, that (we) last saw the deceased alive on 6 June 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
J. Dixon Hills					6 June 1967				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
J. Dixon Hills					JOHN HOPKINS HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE				
Rem. Burial					6/8/1967				
24C. NAME OF CEMETERY or CREMATORY					24D. LOCATION (City, town, or county) (State)				
Mt. Saviour Monastery					Pine City, N. Y.				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR				
JUN 8 1967					H. W. Jenkins, & Sons Co. 4905 York Rd. Balto. 12, Md.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5545		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5545	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) ALAN P. LONGCOPE			2. DATE AND HOUR OF DEATH 6/7/67 8:35 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME AND HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 8. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 218 PRESTON ST.		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 11-14-89	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAW SECRETARY			10B. KIND OF BUSINESS OR INDUSTRY LEGAL		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME GEORGE LONGCOPE		
14. MOTHER'S MAIDEN NAME RUTH THEOBALD			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I		
16. SOCIAL SECURITY NO. 21501-5659			17. INFORMANT FRANCES T. LONGCOPE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CEREBROVASCULAR ACCIDENT			INTERVAL BETWEEN ONSET AND DEATH HOURS		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II			20. DUE TO AURICULAR FIBRILLATION YEARS		
21. DUE TO ARTERIOSCLEROTIC HEART DISEASE YEARS			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that it (this hospital) attended the deceased from 6-6-1967 to 6-7-1967 , that it (we) last saw the deceased alive on 6-6-1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, it (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED 6-7-67		
23C. PHYSICIAN'S NAME (Type) NENITA SUAREZ			23D. ADDRESS CHURCH HOME & HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-9-67		24C. NAME of CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR H.M. Jenkins & Sons Co.	
25D. ADDRESS 4905 York Rd.					

017/1

MARYLAND

LOCALITIES

THE REGISTER OF

11-14-81 JJ

MARYLAND

RUTH THEODORA

GEORGE LONGCOPE

CENTRAL-AMERICAN AIRCRAFT

ALL THE AIRCRAFT

AT THE AIRCRAFT

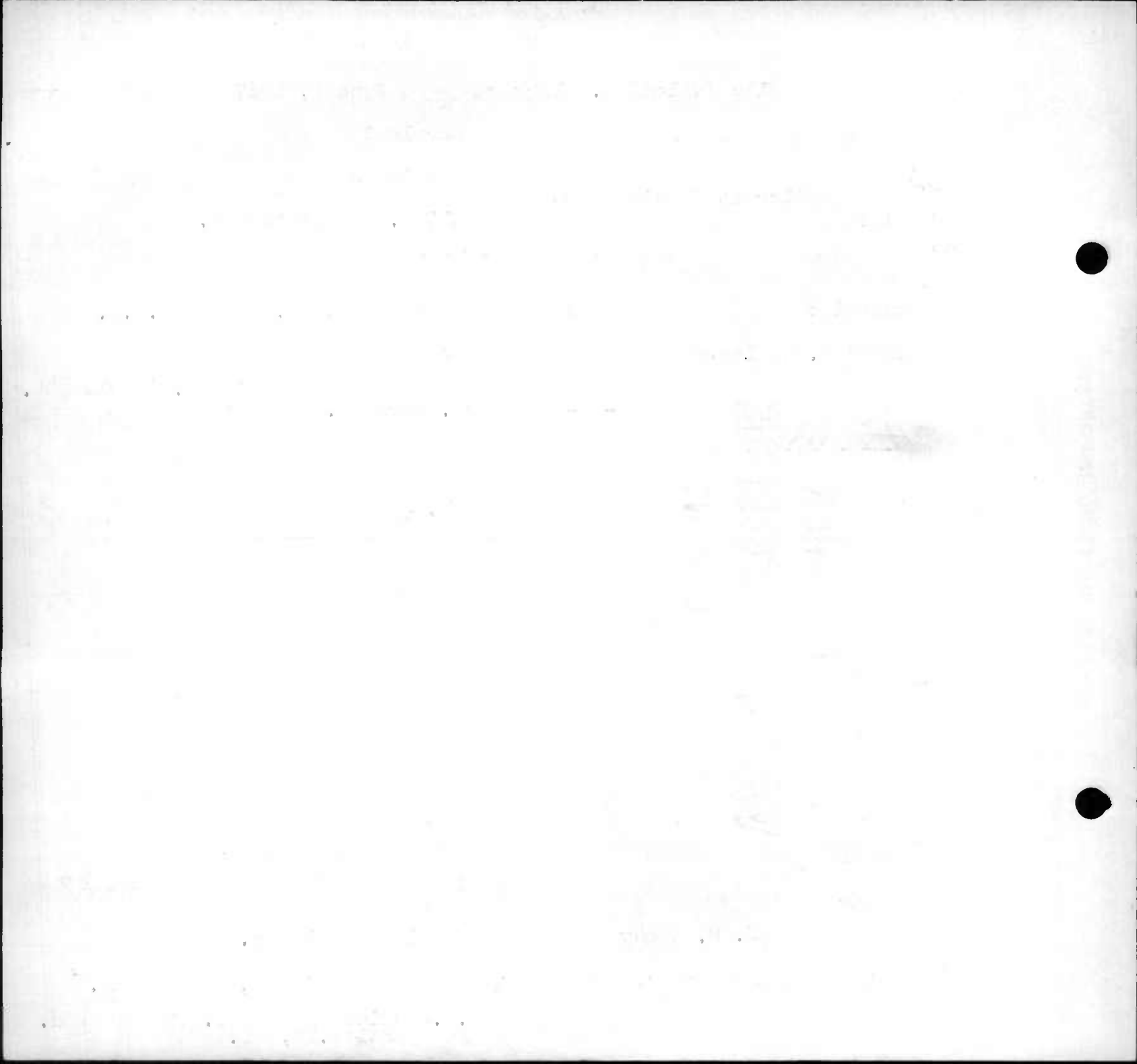
2-2
2-2

February

MONITOR

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5546</u>	
BIRTH NO. <u>67 5546</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Ella (Ellen) W. Clark</u>		2. DATE AND HOUR OF DEATH <u>June 8, 1967</u> <u>15⁴⁵</u> <u>A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Hillcrest Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>117 W. Lafayette Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1/21/1878</u>	9. AGE (In years last birthday) <u>89</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward H. Wellmore</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Maher</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>082-14-3088D</u>		17. INFORMANT <u>Mrs. George J. Clautice</u> ADDRESS <u>4528 N. Charles St.</u>	
18. <u>443X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury at complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cerebro-vascular disease</u> <u>Hypertension</u> <u>Myocarditis</u> <u>Exhausted</u> (B) _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>11</u> <u>3 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <u>Oct 1962</u> to <u>6-8-67</u> 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>June 7</u> 19 <u>67</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>W. H. Woody</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6-8-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>W. H. Woody</u>		23D. ADDRESS <u>1403 Park Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/10/1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 8 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>	
25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HELEN IRENE SMITH

2. DATE AND HOUR PRONOUNCED DEAD

6-6-67

12:00 M

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5203 Catalpha Road 21214

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

April 21, 1898.

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

G. William Laucht

14. MOTHER'S MAIDEN NAME

Emma VonLindenberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

Unk.

17. INFORMANT

Mr. Clifford L. Smith

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Overdose of barbiturate
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

5203 Catalpha Road, Baltimore 21214

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6 5 '67 2:00 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ingested overdose of barbiturate

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-7-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/10/67.

23C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 8 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

1947, 12 21, 1947

1947, 12 21, 1947

1947, 12 21, 1947

1947, 12 21, 1947

1947, 12 21, 1947

1947, 12 21, 1947

1947, 12 21, 1947

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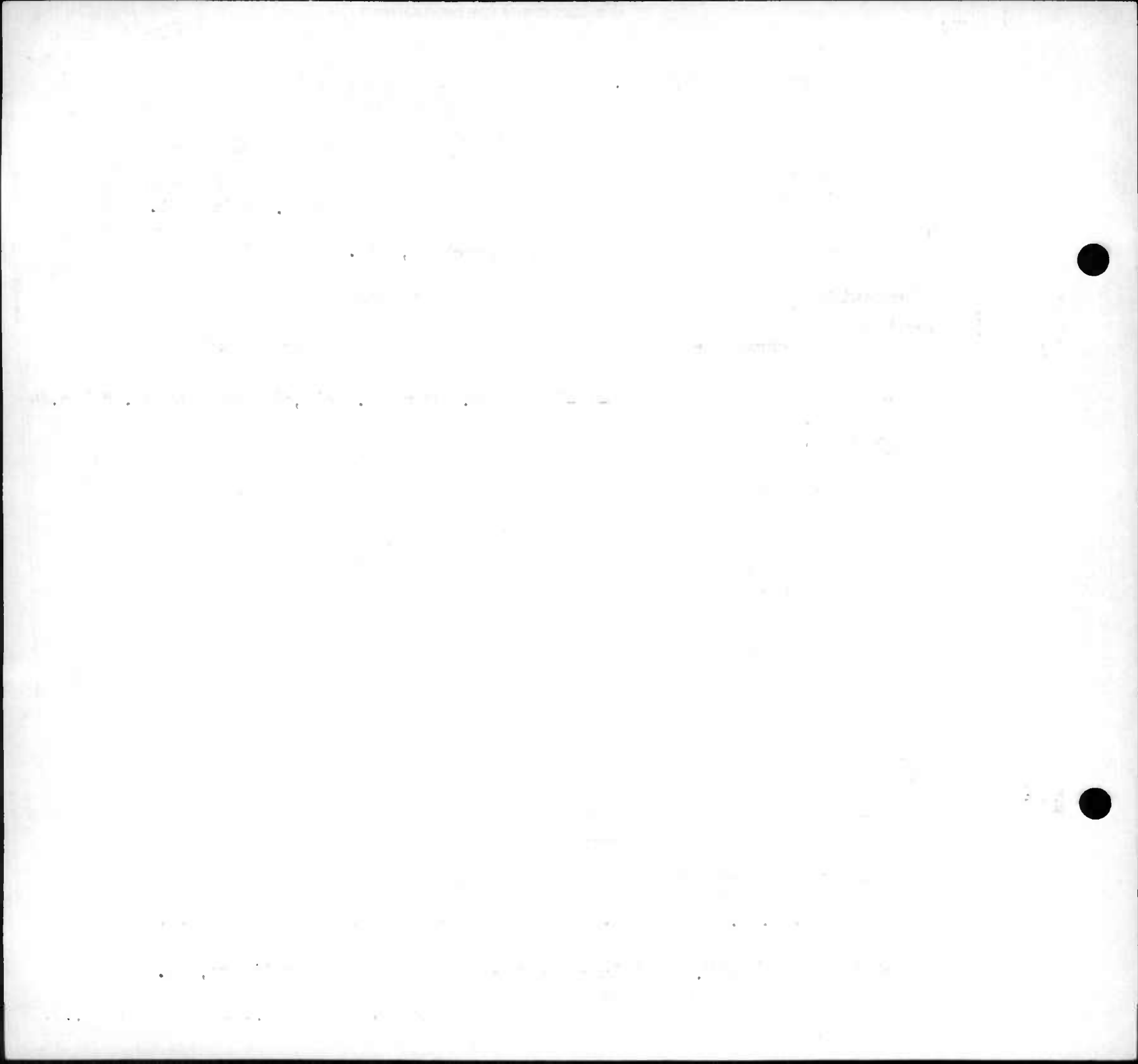
1947, 12 21, 1947

1947, 12 21, 1947

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

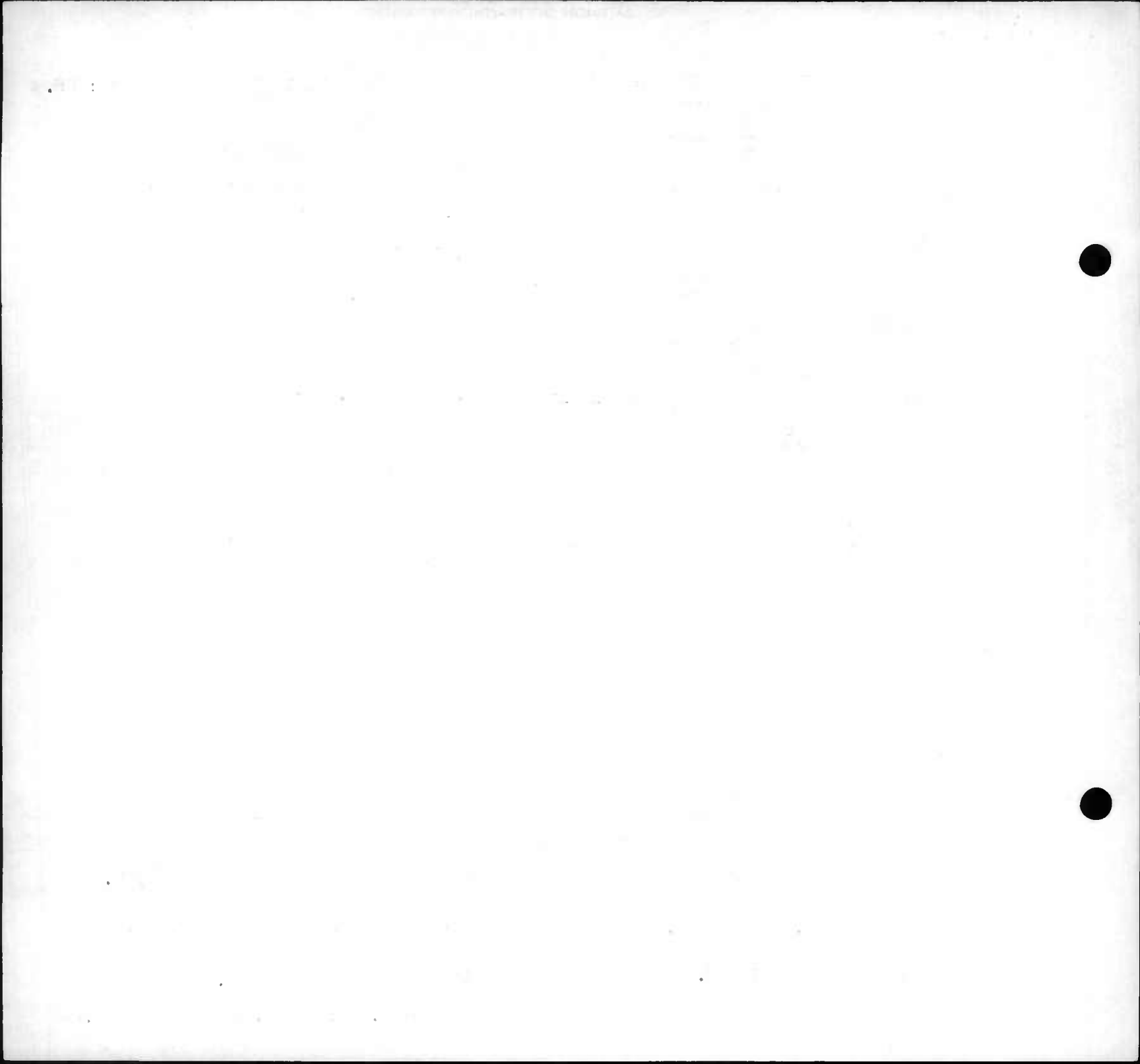
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5548</u>	
BIRTH NO. <u>67 5548</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MARGERITE XXXXXX A. KEIM</u>		2. DATE AND HOUR OF DEATH <u>June 7, 1967</u> <u>1 A. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90</u> <u>Belaire House In The Pines</u> <u>5837 Belair Road</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>XXXX 2330 E. Madison St.</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>March 25, 1886.</u>		9. AGE (In years lost birthday) <u>81</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Conrad Poehlman</u>		14. MOTHER'S MAIDEN NAME <u>Lena Schueler</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-14-3694</u>		17. INFORMANT ADDRESS <u>Mr. Conrad C. Keim, 503 Yarmouth Rd. Balto. #4</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>acute coronary occlusion</u>		CAUSE OF DEATH (A) DUE TO <u>arterio-sclerotic heart</u> (B) DUE TO <u>Diabetes</u> (C) <u>myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 years</u> <u>5 years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>no</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>—</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>Mar 8th</u> 19 <u>42</u> to <u>June 7</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 2</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>George Sawyer</u>				23B. DATE SIGNED <u>June 7 - '67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. G. J. Sawyer, Jr.</u>				23D. ADDRESS <u>4808 Harford Rd, Baltimore...14</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/10/67.</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 8 1967</u>		25B. NAME OF REGISTRAR <u>Robert J. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc....Baltimore, Md....14</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5549	
BIRTH NO. 67 5549		CERTIFICATE OF DEATH	
M.E. CASE NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) JOHN DAVID MCGREGOR		June 7, 1967 10:20P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY	
00 2781 The Alameda		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 2781 The Alameda	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Jan. 19, 1888
		9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William McGregor		14. MOTHER'S MAIDEN NAME Catherine McCourt	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-07-3618	
		17. INFORMANT ADDRESS Mrs. Loretta C. McGregor-2781 The Alameda	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 332X		CAUSE OF DEATH Cerebral thrombosis	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO arteriosclerosis, generalized	
		(B) DUE TO sensibility	
		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Emphysema, myocarditis.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 1965 to June 6, 1967 , that (I) (we) last saw the deceased alive on June 5, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Theodore J. Graziano		23B. DATE SIGNED 6/8/67.	
23C. PHYSICIAN'S NAME (Type) Dr. Theodore J. Graziano		23D. ADDRESS 2802 Harford Rd, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 6/10/67.	
24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Baltimore, Md.--14	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5550	
BIRTH NO. 67 5550		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Coale, Otho Skipwith		2. DATE AND HOUR OF DEATH 3:10 pm June 7, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21214		27-06	
		D. STREET ADDRESS (If rural, give location) 5601 Fair Oaks Ave.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 08-05-00	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co.		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME Webster N. Coale		14. MOTHER'S MAIDEN NAME Edith Bradford	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-7333		17. INFORMANT Mrs. Dallas F. Coale	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 5 days		(A) DUE TO Cardiac Arrest.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3:06 pm June 2 1967 to 3:10 pm June 7 1967 , that (I) (we) last saw the deceased alive on 3:10 pm June 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sang Won Song		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 7, 1967	
23C. PHYSICIAN'S NAME (Type) SANG WON SONG		23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/10/67.		24C. NAME OF CEMETERY or CREMATORY Western Cemetery	
24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	

3:10 PM June 7 1961

Case: John Smith

Md
Baltimore
201 Fair Lakes Ave

The Nixon Memorial Hospital

08-02-00 00

M W M

Baltimore
America

John Smith

Edith Brantley

Webster, Cole

201 Fair Lakes Ave

Center Municipal Institution Building
Criminal Court

3:10 PM June 7 1961
3:10 PM June 7 1961

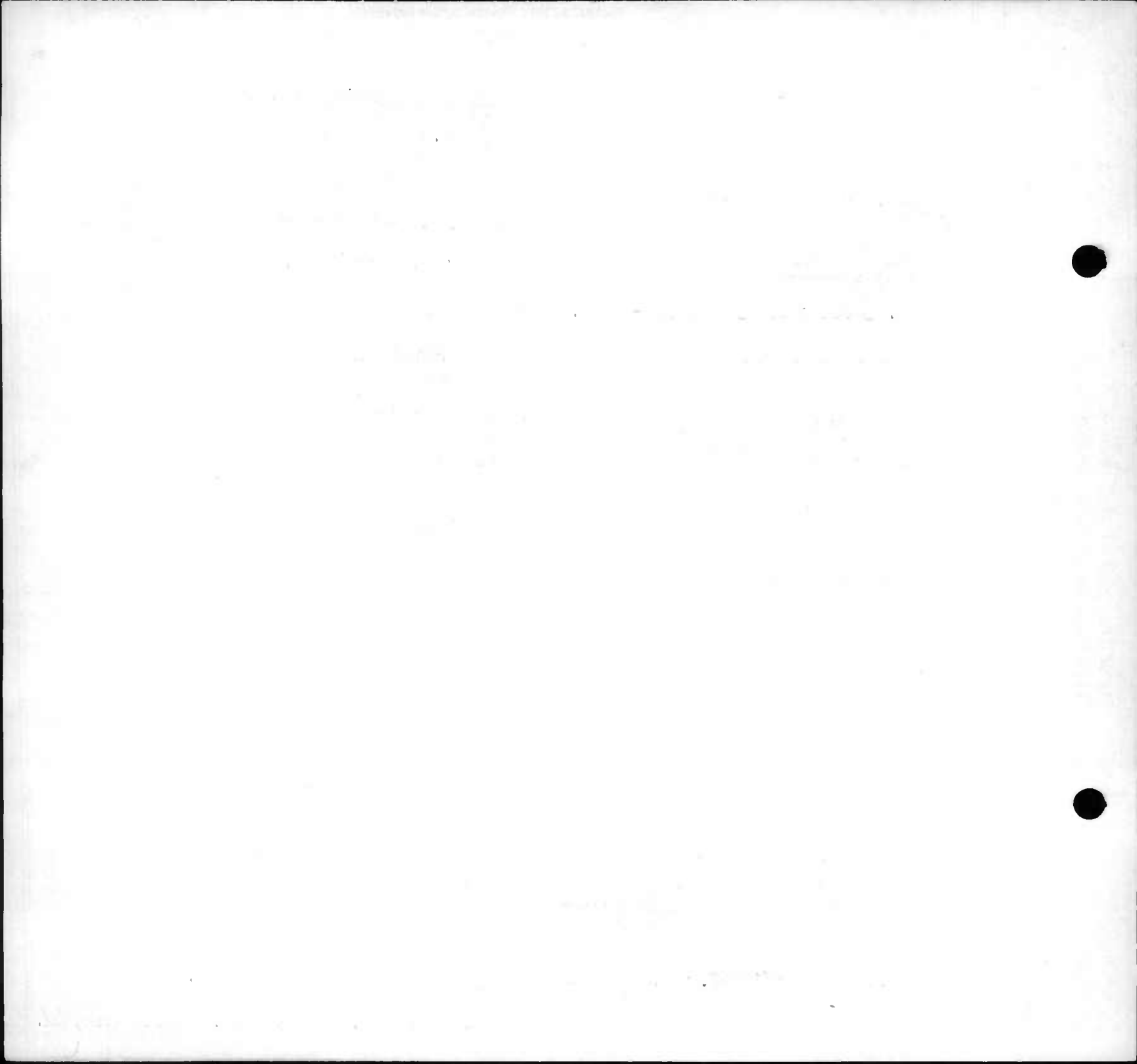
June 7 1961

Handwritten signature

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5551 CERTIFICATE OF DEATH					Registered No. 67 5551				
BIRTH NO. M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <i>Frank Bellistri</i>					June 7, 1967 1:20 PM M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>2309 Harford Road</i>					A. STATE <i>Md.</i> B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
					D. STREET ADDRESS (If rural, give location) <i>2309 Harford Road</i>				
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>Jan. 17, 1889</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Furniture Finisher-Dept. store</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Italy</i>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Joseph Bellistri</i>			14. MOTHER'S MAIDEN NAME <i>Abalonia</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>216015679</i>		17. INFORMANT <i>Josephine Bellistri</i>		ADDRESS <i>same</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>177X I</i>					CAUSE OF DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO <i>Metastatic Carcinoma (Prostate)</i>				
					(B) DUE TO <i>Coronary Vascular and disease</i>				
					(C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>March 1957</i> to <i>June 7 1967</i> , that (I) (we) last saw the deceased alive on <i>June 7 1967</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>M. J. Grossfeld</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6-7-67</i>		
23C. PHYSICIAN'S NAME (Type) <i>MICHAEL J. GROSSFELD, M.D.</i>					23D. ADDRESS <i>MICHAEL J. GROSSFELD, M.D. 5402 Belair Road Baltimore, Md. 21206</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>6/12/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 8 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i>					
					ADDRESS <i>Baltimore, Md.</i>				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
James, India		6-5-67 8:55A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location)			
90 Duke Land Nursing Home 1501 Duke Land Street		Maryland Harford Co. Dorlington RFD 2 - Box 125			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	N	Widowed	6-4-90	77	1
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Housewife		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John Haines		Mary Joaman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		218-54-2590N		Duke Land Nursing Home - 1501 Duke Land St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
Arteriosclerotic C-V Disease					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2-16-1967 to 6-5-1967 that (I) (we) last saw the deceased alive on 6-5-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Percival C. Smith				6-5-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Percival C. Smith		M.D. 1709 Gwynns Falls Parkway			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-10-67		Berkley Cemetery	
				Dorlington Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 8 1967		R. E. Fisher		712-14 Bullock Funeral Home & North ave	

90 7
John Staines
Mary Staines
Washington, D.C.

24-24-24

John Staines

Frank C. Smith

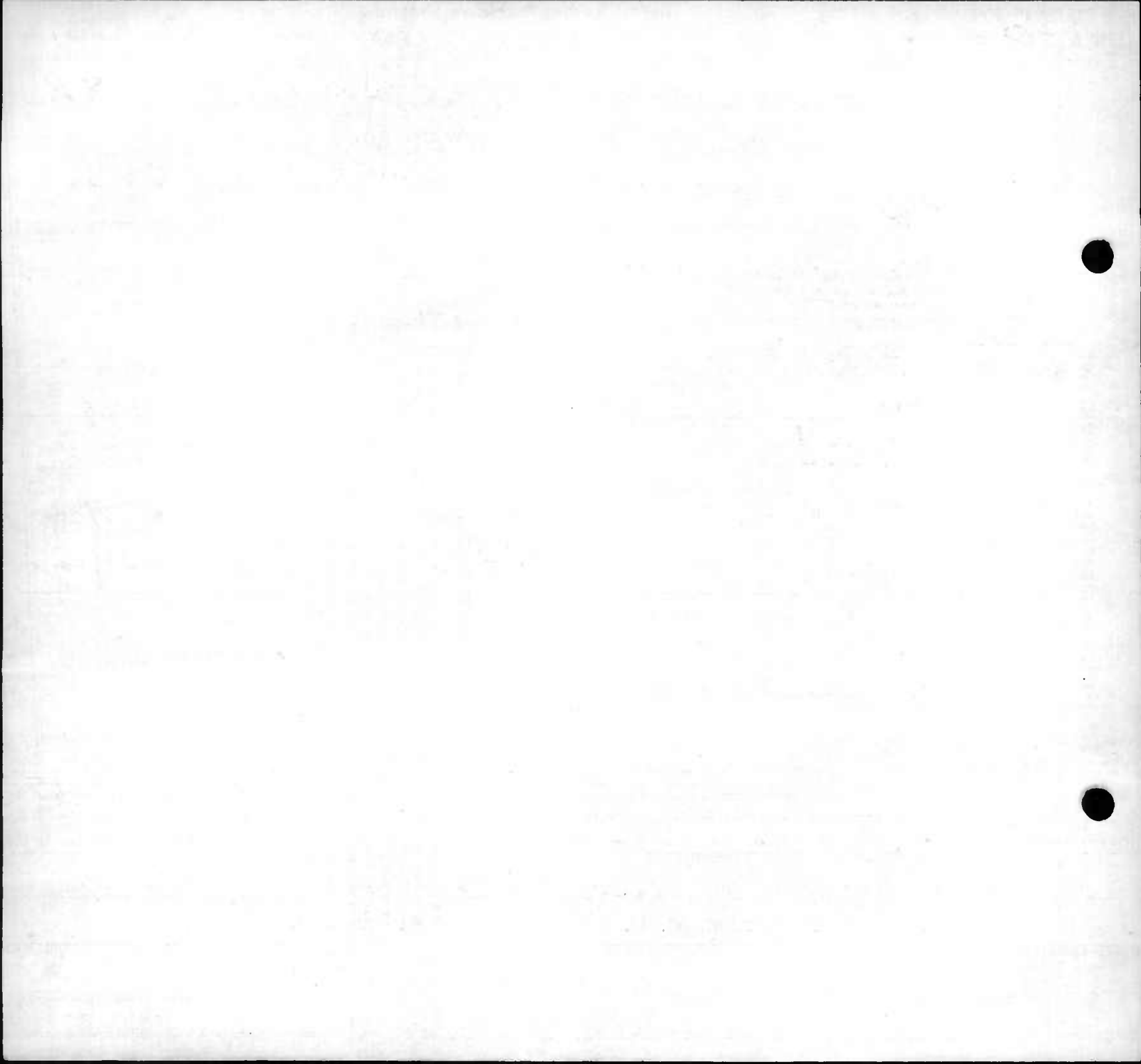
✓

Exhibit 1-10-67
Washington, D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5553</u>	
BIRTH NO. <u>67 5553</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>LESTER LONDER</u>			
2. DATE AND HOUR OF DEATH <u>JUNE 5, 1967</u> <u>8 A</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-48</u> D. STREET ADDRESS (If rural, give location) <u>1204 WOODBOURNE AVE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>1204 WOODBOURNE AVENUE</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>2/11/1925</u>	9. AGE (In years last birthday) <u>39</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>HARRY</u>		14. MOTHER'S MAIDEN NAME <u>BESSIE</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-22-9541</u>		17. INFORMANT <u>WIFE</u> ADDRESS <u>SAME</u>	
18. <u>002.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <u>Hemorrhage from Lung</u> (B) DUE TO <u>Bronchitis</u> (C) <u>J.B.C.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 1/2 hrs</u> <u>1 wk</u> <u>23 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-12</u> 19 <u>66</u> to <u>6-5</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-3</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Coral Gordon</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6-6-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Coral Gordon, M. D.</u>		23D. ADDRESS <u>611 Park Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/7/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Hebrew Friendship</u>	
24D. LOCATION (City, town, or county) <u>Balto</u>		(State) <u>Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 8 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Byrnes & Lewis & Son, Inc</u> ADDRESS <u>Garrison</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5554	
BIRTH NO. 67 5554		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Hertrude GOLDSTEIN		2. DATE AND HOUR OF DEATH JUNE 6, 1967 12 Noon M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Balts. C.		5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP. OF BALTIMORE		D. STREET ADDRESS (If rural, give location) 6649 Wycombe Way # 34			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7/8/1907	9. AGE (In years last birthday) 59	10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House WIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JACOB		14. MOTHER'S MAIDEN NAME CELIA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT BERTRAM GOLDSTEIN 4504 SUTTS LANE CT	
18. 493 X 9170 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia, Right lower lobe 24 hours.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 1) Carcinoma of BREAST 2 met 2) A SCUDE tolycardia				1 year. terminal	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from July 19 64 to June 6 1967 , that (I) (we) last saw the deceased alive on June 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Sheldon Goldstein M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 6, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/8/67		24C. NAME OF CEMETERY OR CREMATORY Beth El	
24D. LOCATION (City, town, or county) (State) Randallstown Md		25A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		25B. NAME OF REGISTRAR Robert E. Farkes, M.D.	
25C. FUNERAL DIRECTOR Sheldon Goldstein, INC		ADDRESS Garrison Md			

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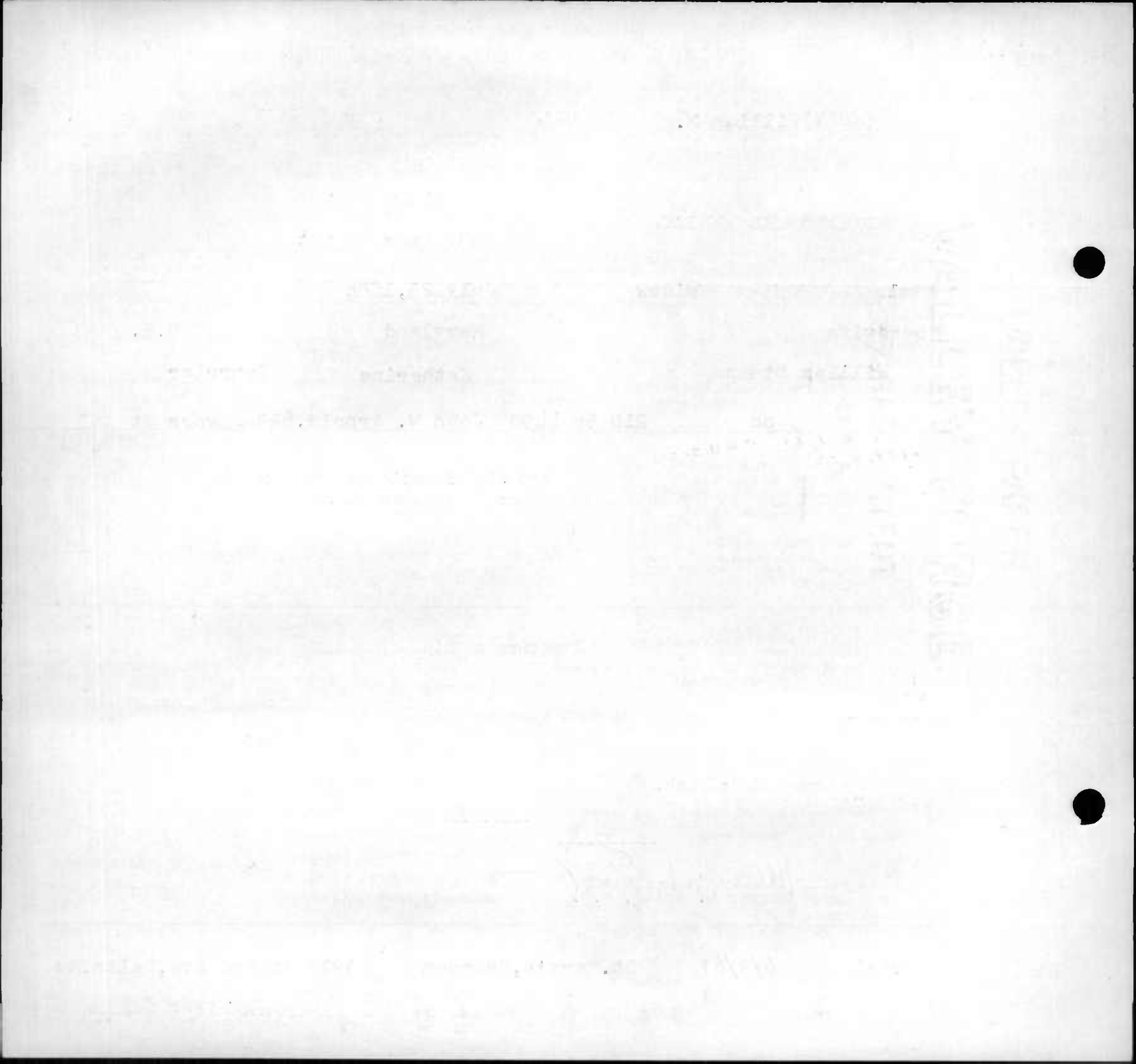
BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 5555 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5555

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (LILLY) Lillian M. ARNOLD				2. DATE AND HOUR PRONOUNCED DEAD June 5, 1967 4:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 813 Powers Street			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widow m	8. DATE OF BIRTH July 23, 1884	9. AGE (In years last birthday) 82	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME William Stump				14. MOTHER'S MAIDEN NAME Katherine Spurrier			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216 56 4490		17. INFORMANT ADDRESS John W. Arnold. 813 Powers St			
18. CAUSE OF DEATH 443 X 45904.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic and Hypertensive XXXXX Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture of Hip						INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 813 Powers Street			
21D. TIME OF INJURY (APPROX.) May 31 '67 Unk.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell at home			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/6/67							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/9/67		23C. NAME OF CEMETERY or CREMATORY St. Mary's, Hampden		23D. LOCATION (City, town, or county) (State) 3900 Roland Ave Balto, Md	
24A. DATE REC'D BY HEALTH DEPT. JUN 8 1967		24B. NAME OF REGISTRAR A. E. Taylor		24C. FUNERAL DIRECTOR ADDRESS Austin E. Donovan - 3815 Roland Ave.			

14820.0



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 5556		REGISTERED NO. 67 5556	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <i>William Francis Russell</i>				2. DATE AND HOUR OF DEATH <i>June 6, 1967 12:10 A. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>00 6507 Alta Avenue</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>6507 Alta Avenue -21206</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>April 10, 1914</i>	9. AGE (In years lost birthday) <i>53</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Line Leader</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Schaefer Brewery</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Russell</i>			14. MOTHER'S MAIDEN NAME <i>Myrtle Smith</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-09-7217</i>		17. INFORMANT <i>Laura Mae Russell-6507 Alta Ave.-21206</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>150 X I Curcunoma of esophagus</i>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>June 5</i> 19 <i>1967</i> to <i>June 6</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>June 2</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Adam G. Swiss</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>June 6, 1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>ADAM G. SWISS</i>				23D. ADDRESS M.D. <i>6232 BELAIR ROAD, BALTIMORE MD.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-8-67</i>	24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
25A. DATE RECEIVED BY HEALTH DEPT. <i>JUN 9 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, MD</i>		25C. FUNERAL DIRECTOR <i>John C. Miller Inc-6415 Belair Road-21206</i>			

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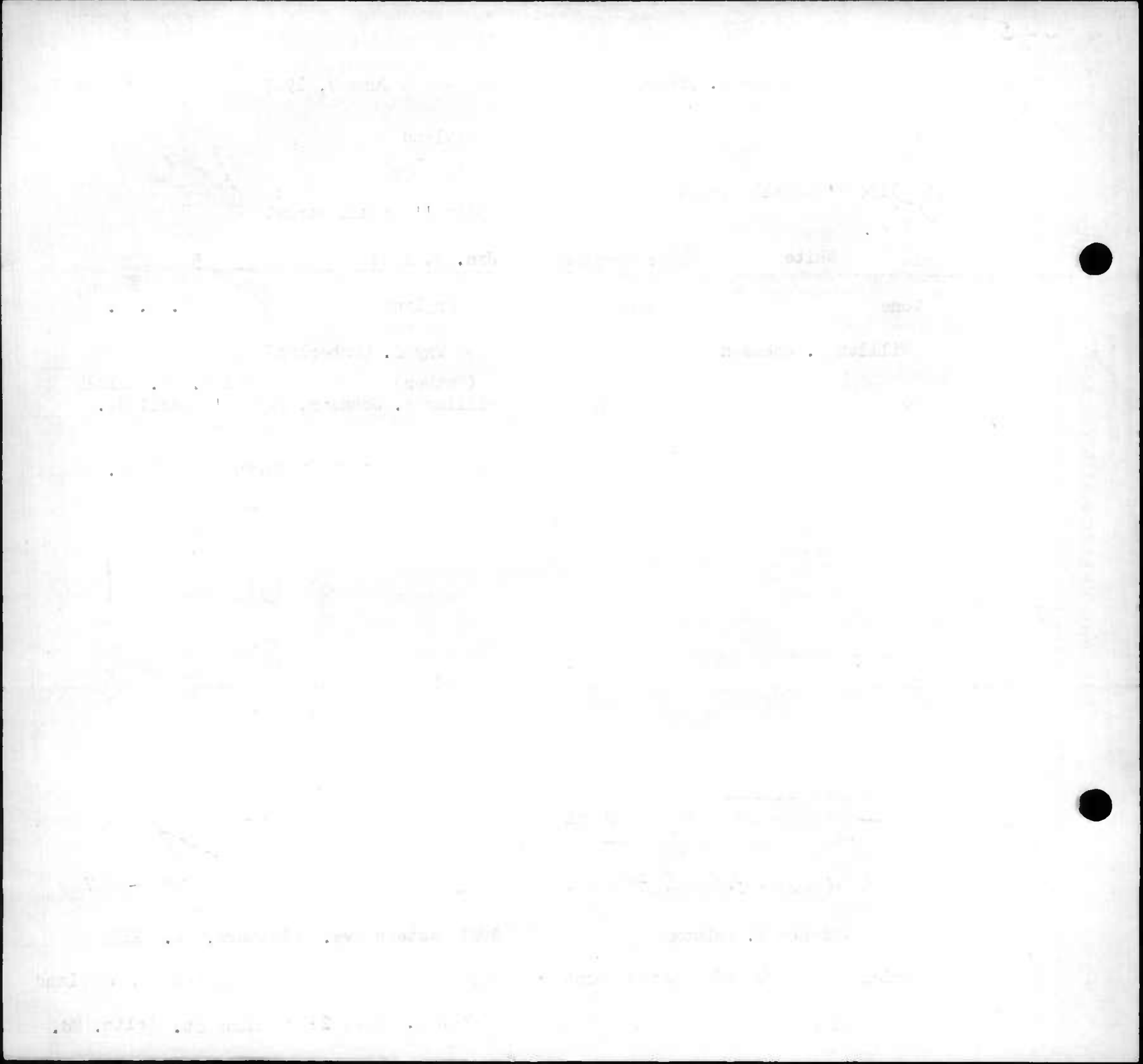
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>67 5557</u>	
BIRTH NO. <u>67 5557</u>							
M.E. CASE NO. <u>67-00268</u>							
1. NAME OF DECEASED (Type or Print) <u>George M. Johnson</u>				2. DATE AND HOUR OF DEATH <u>June 7, 1967</u>		<u>9:45 A. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>3136 O'Donnell Street</u>				A. STATE <u>Maryland</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>3136 O'Donnell Street</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>Jan. 8, 1967</u>	9. AGE (In years last birthday) <u>5</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>William F. Johnson</u>				14. MOTHER'S MAIDEN NAME <u>May S. Cumberland</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT (Father) <u>Balto. Md. 21224</u> <u>William F. Johnson, 3136 O'Donnell St.</u>			
18. <u>754.5 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Congenital Heart Disease</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>5 Mo.</u>	
				(B) _____ DUE TO			
(C) _____ DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March 6</u> 19 <u>67</u> to <u>June 7</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 7</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Clarence W. LeDoux</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>June 7-1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>Clarence W. LeDoux</u>				23D. ADDRESS <u>3023 Eastern Ave. Baltimore, Md. 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/10/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Sandy Mount Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Carroll County, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 9 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>John J. Duda, 2829 Hudson St. Balto. Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 67 5558				
BIRTH NO. 67 5558									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)		KILPATRICK, RAYMOND VIRGINIUS			2. DATE AND HOUR OF DEATH			JUNE 6, 1967 9:00A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)			A. STATE		B. COUNTY		
ST. AGNES HOSPITAL					MARYLAND		ANNE ARUNDEL COUNTY		
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					PASADENA 21122				
					D. STREET ADDRESS (If rural, give location)				
					CIRCLE RD LONG POINT RT #1				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED		8. DATE OF BIRTH	9. AGE (In years)	If Under 1 Yr.		If Under 24 Hrs.	
MALE	WHITE	MARRIED		6-21-95	71	Months Days		Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
RETIRED (Foreman)		GENERAL REFRACTORIES VIRGINIA				U.S.A.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
JOHN KILPATRICK					MARY WEST				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
YES		WORLD WAR 1		214-05-3741 ST. AGNES HOSPITAL RECORDS					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) CARCINOMA OF RIGHT LUNG				
					DUE TO				
					(B) SILICOTUBERCULOSIS IN BOTH LUNGS				
					DUE TO				
					(C)				
19. ANTECEDENT CAUSES					INTERVAL BETWEEN ONSET AND DEATH				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from MAY 28 19 67 , to JUNE 6 19 67 , that (I) (we) last saw the deceased alive on JUNE 6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED	
R.M. REVILLA									
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
					ST. AGNES HOSP; CATON & WILKENS				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		June 8, 1967		Baltimore National Cem.		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS					
JUN 9 1967		Robert E. Talbot		George J. Gonca- 4001 Ritchie Hwy., Baltimore Md.					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5559	
BIRTH NO. 67 5559		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MILLER, LYNN H.		2. DATE AND HOUR OF DEATH 6/7/67 1:A.M. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL				A. STATE MARYLAND B. COUNTY Balto Co.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21228 53-00			
				D. STREET ADDRESS (If rural, give location) 24 EDMONDSON RIDGE ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11/25/93	9. AGE (In years last birthday) 73	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED carpenter building			11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES UNKNOWN			16. SOCIAL SECURITY NO. 106 03 1362		17. INFORMANT ADDRESS ST AGNES RECORDS CATON & WILKENS		
18. 434.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Congestive heart failure (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/6/67 19 to 6/7/67 19, that (I) (we) last saw the deceased alive on 6/7/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Susan Korbuly SUSAN KORBULY				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) SUSAN KORBULY				23D. ADDRESS M.D. ST. AGNES HOSPITAL CATON & WILKENS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 9, 1967		24C. NAME OF CEMETERY or CREMATORY Lakeview Mem. Park		24D. LOCATION (City, town, or county) (State) Carroll County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1967		25B. NAME OF REGISTRAR Robert E. Fadden, M.D.		25C. FUNERAL DIRECTOR ADDRESS STERLING FUNERAL ESTATE 736 Edm. Av. 55 Catonsville, Md.			

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67 5560

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5560

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SUE

GINGRAS

2. DATE AND HOUR PRONOUNCED DEAD

6-6-67

2:30 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1085 Prospect Avenue 21228

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

APRIL 21-1947

9. AGE (In years
last birthday)

20

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

STENOGRAPHER

10B. KIND OF BUSINESS OR INDUSTRY

HOUSE WIFE

11. BIRTHPLACE (State or foreign country)

PHILLIPSBURG N.JERSEY

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ROBERT J. HUPPMAN

14. MOTHER'S MAIDEN NAME

GENEVRA BENTLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

186-36-1898

17. INFORMANT

ROBERT J. HUPPMAN

ADDRESS

108 S. PROSPECT AVE

18. E 916.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Extensive burns - 75% of body surface
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

108 S. Prospect Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6 2 '67 4:34 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Gas stove exploded

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

6-7-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

JUNE 9-1967

23C. NAME OF CEMETERY or CREMATORY

LOUDON PARK

23D. LOCATION

(City, town, or county)

BALTIMORE MD

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 9 1967

GEORGE A. FARLEY

6601 FREDERICK AVE

STATIONARY HOUSE NO. 2
ROBERT J. HUBBARD
GENERAL BLANK

IN THE DISTRICT COURT OF THE
SOUTHERN DISTRICT OF NEW YORK
IN SENATE
JANUARY 1900

IN SENATE
JANUARY 1900
JANUARY 1900

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5561	
BIRTH NO. 67 5561		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) OLIVER L. HOOVER		2. DATE AND HOUR OF DEATH JUNE 3, 1967 1³⁵ P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSP		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2701 W. BELVEDERE AVE -15			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/25/02	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUDITING		10B. KIND OF BUSINESS OR INDUSTRY D&O R.R.		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME ?			
14. MOTHER'S MAIDEN NAME ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 216-03-2216		17. INFORMANT PAULANNE HOOVER (SAME)			
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) lung ca = generalized metastasis		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-4 19 67 to 6-3 19 67 , that (I) (we) last saw the deceased alive on 6-3, 1:35 PM 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Pyoung IL KWON		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-3-67	
23C. PHYSICIAN'S NAME (Type) PYOUNG IL KWON		23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/7/67		24C. NAME OF CEMETERY or CREMATORY IMMANUEL LUTHERAN	
24D. LOCATION (City, town, or county) (State) MANCHESTER MD.					
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1967		25B. NAME OF REGISTRAR Robert E. Fagan		25C. FUNERAL DIRECTOR Wm. S. Fagan	
ADDRESS 3617 Chestnut Ave.					

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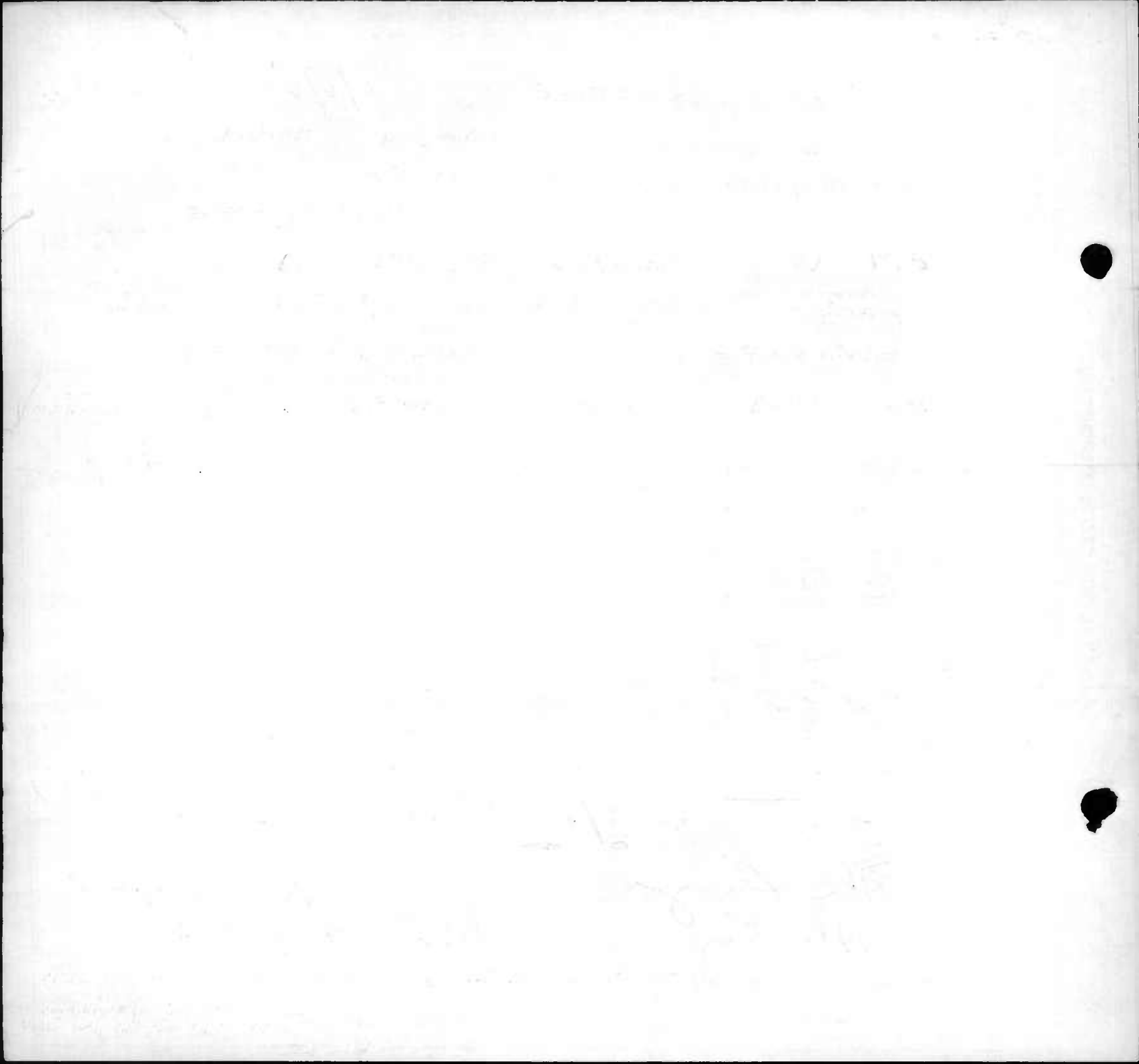
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

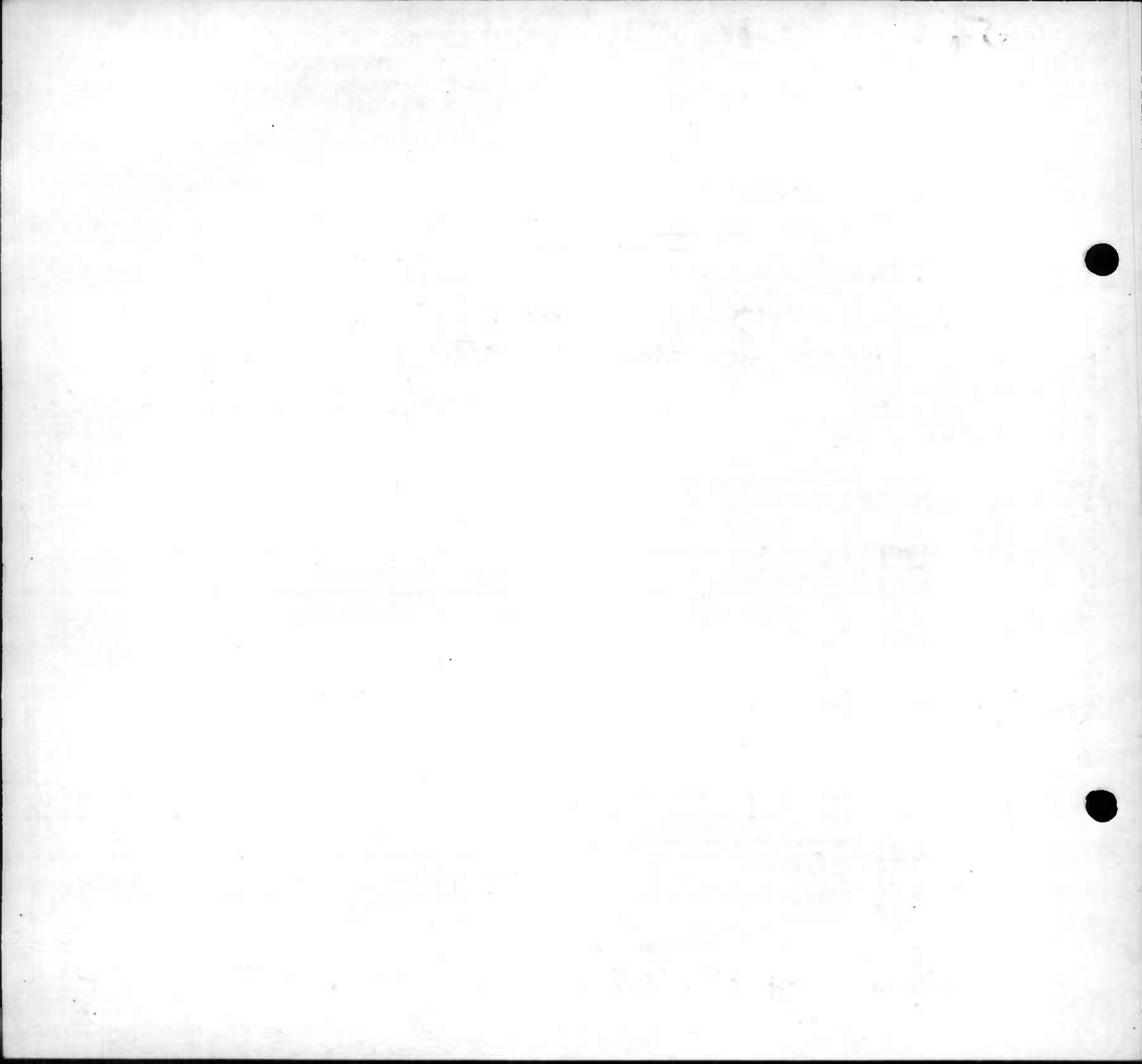
BALTIMORE CITY HEALTH DEPARTMENT									
67 5562					Registered No. 67 5562				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Edwin Justice					2. DATE AND HOUR OF DEATH 6/6/67 6:45 p.m.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE 42					A. STATE Maryland				
					B. COUNTY Harford Co.				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Bel Air 62-32				
					D. STREET ADDRESS (If rural, give location) 710 Rock Spring Avenue				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH July 27, 1918	9. AGE (In years last birthday) 48	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor				10B. KIND OF BUSINESS OR INDUSTRY Building Construction		11. BIRTHPLACE (State or foreign country) Howard Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwin Justice					14. MOTHER'S MAIDEN NAME Lelia Mae Brandenburg				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII				16. SOCIAL SECURITY NO. 212-03-3553		17. INFORMANT (W.R.) 838-7505 Mrs. Jean E. Justice		ADDRESS 710 Rock Spring Ave. Bel Air, Maryland 21014	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION					INTERVAL BETWEEN ONSET AND DEATH 48 hours				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 6/4 19 67 to 6/6 19 67 , that (I) (we) last saw the deceased alive on 6/6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (he) (did) (did not) view the body after death.									
23A. SIGNATURE Abbe Levy					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6/6/67	
23C. PHYSICIAN'S NAME (Type) Abbe Levy					23D. ADDRESS Sinai Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE JUNE 9, 1967		24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens		24D. LOCATION (City, town, or county) (State) Bel Air, Harford Co., Maryland 21014			
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1967		25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams Bel Air, Maryland 21014				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

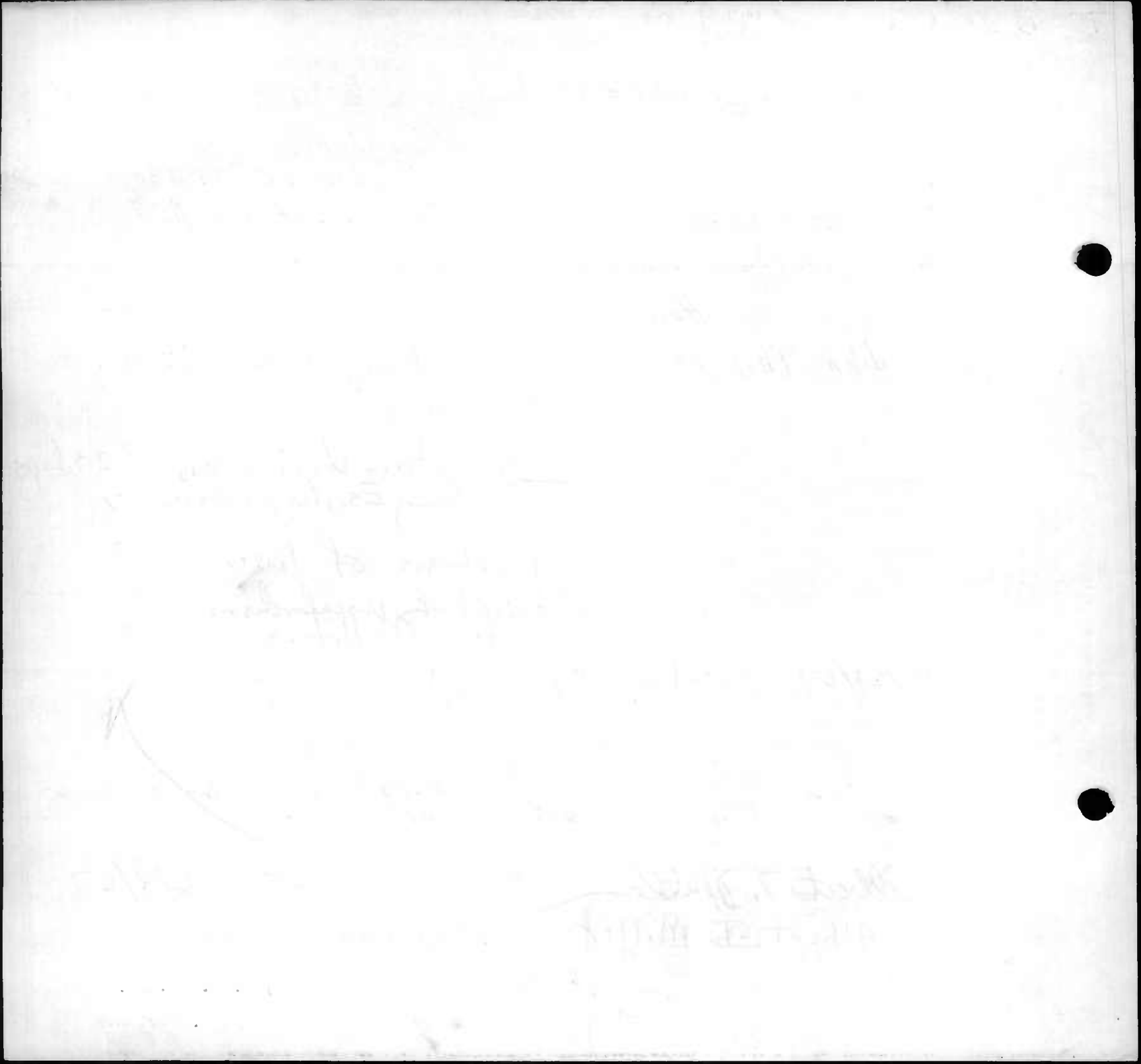
BIRTH NO. 67 5563		CERTIFICATE OF DEATH		Registered No. 67 5563	
M.E. CASE NO. 67-10478					
1. NAME OF DECEASED (Type or Print) <i>Melvin Lee HARRISON Jr</i>		2. DATE AND HOUR OF DEATH <i>June 5, 1967 2:35 AM.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lutheran Hospital of Maryland 46</i>		A. STATE <i>Maryland</i> B. COUNTY <i>A.A.C.</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Pasadena 52-00</i>			
		D. STREET ADDRESS (If rural, give location) <i>RT. 5, Box 90-B</i>			
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED NEVER MARRIED WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH <i>6-4-67</i>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<i>None</i>		<i>None</i>	<i>Maryland</i>		<i>USA</i>
13. FATHER'S NAME <i>Melvin Lee Harrison</i>			14. MOTHER'S MAIDEN NAME <i>Judith G. RAY</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Melvin L. Harrison Jr - Above</i>		
			ADDRESS		
18. <i>760.0 I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <i>Cerebral hypoxia</i>		<i>7 PM 6/4/67</i>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) <i>Cerebral hemorrhage</i>		<i>2:35 AM 6/5/67</i>	
ANTECEDENT CAUSES		(C)		<i>7 hrs. 35 min.</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<i>0</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7 PM 6/4 1967</i> to <i>2:35 AM 6/5 1967</i> , that (I) (we) last saw the deceased alive on <i>6/5 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Shingall Kim</i>				23B. DATE SIGNED <i>6/5/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Shingall Kim</i>				23D. ADDRESS <i>Lutheran Hosp, Inc, Baltimore.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>6/8/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Beth National Cem</i>	
<i>Burial</i>				<i>Baltimore</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 9 1967</i>		25B. NAME OF REGISTRAR <i>Robert S. Barranco</i>		25C. FUNERAL DIRECTOR <i>Robert S. Barranco</i>	
				ADDRESS <i>Severna Park, Md</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5564	
BIRTH NO. 67 5564		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Helen Marie Truckenmiller</i>		2. DATE AND HOUR OF DEATH <i>6-8-1967 11:00 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>43 South Baltimore General Hosp.</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21230 24-03</i> D. STREET ADDRESS (If rural, give location) <i>1251 Battery Ave.</i>			
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>12-11-12</i>	9. AGE (In years last birthday) <i>54</i>	If Under 1 Yr. Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		13. FATHER'S NAME <i>John Phillips</i>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i>		18. MOTHER'S MAIDEN NAME <i>Margaret Stumpt</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>581.0 +1 260 X Mesenteric Vein Thrombosis Bleeding Esophageal Varices</i>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <i>Cirrhosis of liver</i>		INTERVAL BETWEEN ONSET AND DEATH <i>? 2-3 days</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Arteriosclerotic Vascular Disease Diabetes Mellitus</i>							
19A. DATE OF OPERATION <i>5-24-67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Portal vein Hypertension VES</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <i>In Baltimore City, give exact location)</i>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from <i>5-13</i> 19 <i>67</i> to <i>6-8</i> 19 <i>67</i> , that the (we) last saw the deceased alive on <i>6-8</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Albert T. Miller</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/8/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Albert T. Miller</i>				23D. ADDRESS <i>1213 Light Street</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6 12 67</i>		24C. NAME of CEMETERY or CREMATORY <i>Cedar Hill</i>		24D. LOCATION (City, town, or county) (State) <i>Brooklyn, A. A. Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 9 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>5 ME Cully</i>		ADDRESS <i>130 E. Fort Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5565	
BIRTH NO. 67 5565		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CLARA HAWKINS		2. DATE AND HOUR OF DEATH 6/8/67 8:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Lisaen Memorial Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 9027 N. CAREY ST		C. CITY OR TOWN (If outside city limits, write RURAL on give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 423 N. POPPLETON ST.			
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1886	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Stoughton, Md	
13. FATHER'S NAME Unknown		12. CITIZEN OF WHAT COUNTRY?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218677556		17. INFORMANT Angela Hawkins 1730 Kenin Rd	
18. 720.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/10/61 19 to 6/8/67 19, that (I) (we) last saw the deceased alive on 6/8/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hollis Seunarine				23B. DATE SIGNED 6/8/67	
23C. PHYSICIAN'S NAME (Type) HOLLIS SEUNARINE				23D. ADDRESS 930 WHITELOCK ST, BALT, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/67		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Chetia Harrison	

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 5587 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5567

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Mazie PRATT		2. DATE AND HOUR PRONOUNCED DEAD 6-6-67 9:25 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) PROVIDENT HOSPITAL - DOA		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 901 N. Stricker Street 21217	
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 2-21-23
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 44
13. FATHER'S NAME Mack Pratt		11. BIRTHPLACE (State or foreign country) Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 216223531		14. MOTHER'S MAIDEN NAME Kate Goldman	
17. INFORMANT Geneva Proctor		ADDRESS 4144 Mt. Wood Road	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. XXXX II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-7-67			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6-10-67	
23C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		23D. LOCATION (City, town, or county) (State) Balto. Md.	
24A. DATE REC'D BY HEALTH DEPT. JUN 9 1967		24B. NAME OF REGISTRAR Robert E. Fisher	
24C. FUNERAL DIRECTOR Kelson Funeral Home		ADDRESS 1348 Calhoun St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 5568		67 5568	
BIRTH NO.				67 5568		Registered No.	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) GEORGE BETHEA			
2. DATE AND HOUR OF DEATH 8 June 67 11 10 A.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV. OF MARYLAND HOSPITAL 38				A. STATE Md B. COUNTY 17-01			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.			
				D. STREET ADDRESS (If rural, give location) 418 N. GREENE ST.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 10/15/98	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY 1		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ? unk.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Chart & Son		ADDRESS	
18. 34031 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Meningitis of unknown etiology				INTERVAL BETWEEN ONSET AND DEATH ?			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6 June 19 67 to 8 June 19 67 , that (I) (we) last saw the deceased alive on 8 June 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stanley Music				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8 June 67	
23C. PHYSICIAN'S NAME (Type) STANLEY MUSIC				23D. ADDRESS % UNIV OF MD, HOSP -			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/67		24C. NAME OF CEMETERY or CREMATORY McKuenburn		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Charles A Rice		ADDRESS 661 W Barr	

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BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BEVERLY CARTER

2. DATE AND HOUR PRONOUNCED DEAD

June 7, 1967 3:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39
99 Provident Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

(-712 Lenox Street) 3718 Gelston Dr.

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

12/2/46

9. AGE (In years
last birthday)

20

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Aloysius Carter

14. MOTHER'S MAIDEN NAME

Bertha Cohen

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Bertha Carter 3718 Gelston Drive

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of face
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

712 Lenox Street

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

6-7-67

3:15 P.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot by unknown assailant

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 8, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/12/67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 9 1967

Robert E. Farley, M.D.

Charlea A. Rice 661 W. Barre St.

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WHOLE LEAF PAPER

WHOLE LEAF PAPER

30-26-75 DH
MS20

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 5570		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5570	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNIE N. MONK		2. DATE AND HOUR OF DEATH 6/6/67 3:20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland #21224				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 20-02 C. CITY OR TOWN If outside city limits, write RURAL and give township BALTIMORE D. STREET ADDRESS (If rural, give location) Mardulia DuVall-2020 Whistler Ave. 306 S. FRANKLINTOWN RD. #21223			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 6-8-1881	9. AGE (In years last birthday) 85	10. CITIZEN OF WHAT COUNTRY? USA		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN Inf.: Mardulia DuVall-2020 Whistler Ave.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMATION BCH 4940 Eastern Avenue RECORDS: Baltimore, Md. #21224			
18. 7829 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Shock - etiology undetermined (B) DUE TO ASVD (C) DUE TO hyperkalemia		INTERVAL BETWEEN ONSET AND DEATH 1 day years.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		diverticulosis					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/28 1966 to 6/6 1967, that (I) (we) last saw the deceased alive on 6/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE David Swimmer M.D.				23B. DATE SIGNED 6/6/67		23C. PHYSICIAN'S NAME (Type) DAVID SWIMMER M.D.	
23D. ADDRESS 4940 Eastern Avenue		Baltimore, Md. #21224					
24A. BURIAL CREMATION, REMOVAL (specify) Burial		24B. DATE 6/9/1967		24C. NAME OF CEMETERY OR CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1967		25B. NAME OF REGISTRAR R. E. ...		25C. FUNERAL DIRECTOR Witzke F.D.		ADDRESS 4101 Edmondson Ave.	

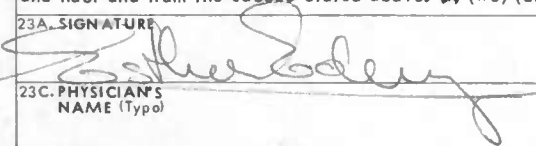
THE OFFICE OF THE SECRETARY

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FUNERAL DIRECTOR: IMPORTANT

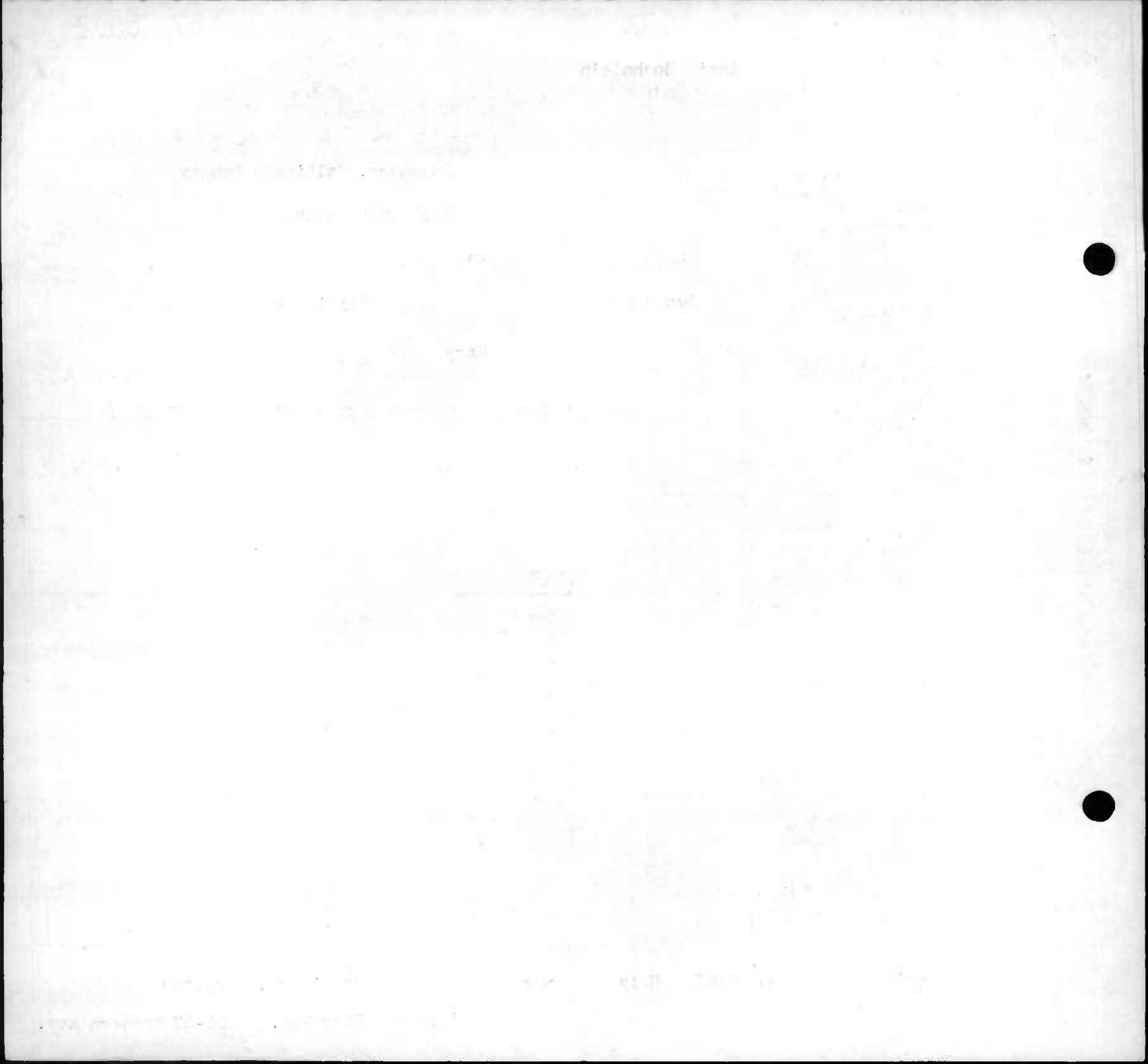
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT															
67 5571 CERTIFICATE OF DEATH						Registered No. 67 5571									
1. NAME OF DECEASED (Type or Print) RICHARDSON, HELEN MARY						2. DATE AND HOUR OF DEATH JUNE 7, 1967 7:15 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE MD 21229						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 21229 B. COUNTY 28-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4260 FLOWERTON ROAD									
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 4-4-88		9. AGE (In years last birthday) 79		10. CITIZEN OF WHAT COUNTRY? USA					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED						10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN									
11. BIRTHPLACE (State or foreign country) MARYLAND						12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME JOSEPH DRESSSEL DEC'D						14. MOTHER'S MAIDEN NAME IDA (GRAYEK) DRESSSEL DEC'D									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO						16. SOCIAL SECURITY NO. 215 05 9750									
17. INFORMANT William L. Richardson-4260 Flowerton Rd.						ADDRESS HOSPITAL RECORDS-ST. AGNES HOSPITAL									
18. CAUSE OF DEATH 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute hemorrhagic pancreatitis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Myocardial Infarction						INTERVAL BETWEEN ONSET AND DEATH									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.															
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 4, 19 67 to JUNE 7, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 7, 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.															
23A. SIGNATURE 								M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 6/8/67			
23C. PHYSICIAN'S NAME (Type) William L. Richardson								23D. ADDRESS M.D. Witzke F. D. - 4101 Edmondson Ave.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 6/12/67				24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.				24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1967				25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR Witzke F. D.				ADDRESS 4101 Edmondson Ave.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5572				BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH				Registered No. 67 5572			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Annie Boehnlein				2. DATE AND HOUR OF DEATH June 7, 1967 1:25 P. M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE 2330 Ruth Ave				B. COUNTY 21219 Balt Co							
48 Maryland Gen. Hosp.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Edgemere, Baltimore County								53-00			
D. STREET ADDRESS (If rural, give location) 2330 Ruth Avenue															
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH Not 11/89		9. AGE (In years last birthday) 77		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Md, Baltimore				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frederick Prietz				14. MOTHER'S MAIDEN NAME Mary Wedamson											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-50-997				17. INFORMANT Marie Durkin				2330 Ruth Ave. 21219			
18. 204.41				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Leukemia				DUE TO				71 month			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(B) _____				DUE TO							
ANTECEDENT CAUSES				(C) _____				DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.															
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				None							
19A. DATE OF OPERATION None				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None				20A. AUTOPSY? (Yes or No) No				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) None				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> None				21F. HOW DID INJURY OCCUR? None							
22. I certify that (I) (this hospital) attended the deceased from 6/7 1967 to 6/7 1967 and that (I) (we) last saw the deceased alive on 6/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.															
23A. SIGNATURE J. Carl Myers				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED							
23C. PHYSICIAN'S NAME (Type) J. Carl Myers				23D. ADDRESS Md. Gen. Hosp. Balto. Md.											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 6-10-1967				24C. NAME OF CEMETERY or CREMATORY Holy Redeemer				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1967				25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.				ADDRESS 1901-07 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
67 5573 CERTIFICATE OF DEATH					Registered No. 67 5573									
BIRTH NO.					M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH									
VALENTINE NEYOLA (VINCENT G. ROSS)					June 4, 1967									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1703 Linden Ave.					A. STATE Maryland									
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore									
D. STREET ADDRESS (If rural, give location) 1703 Linden Ave.					5. SEX Male									
					6. RACE Filipino									
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married					8. DATE OF BIRTH Jan 22, 1895		9. AGE (In years last birthday) 72		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman					11. BIRTHPLACE (State or foreign country) Philippine Islands					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 217-16-7757		17. INFORMANT Mrs. Dorothy Ross 1703 Linden Ave							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>Carcinoma of Lung</i> DUE TO (B) _____ DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from May 19 1967 to June 3 1967, that (I) (we) last saw the deceased alive on June 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <i>Samuel J. Hunter</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED June 8 1967				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D. 3579 Liberty Perry									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 6/8/67					24C. NAME OF CEMETERY or CREMATORY Locust Chapel Cemetery				
					24D. LOCATION Simpsonville, Maryland									
25A. DATE RECEIVED BY HEALTH DEPT. JUN 9 1967					25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>					25C. FUNERAL DIRECTOR Wm C March 928 E. North Ave.				

63 320

63 321

63 321



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

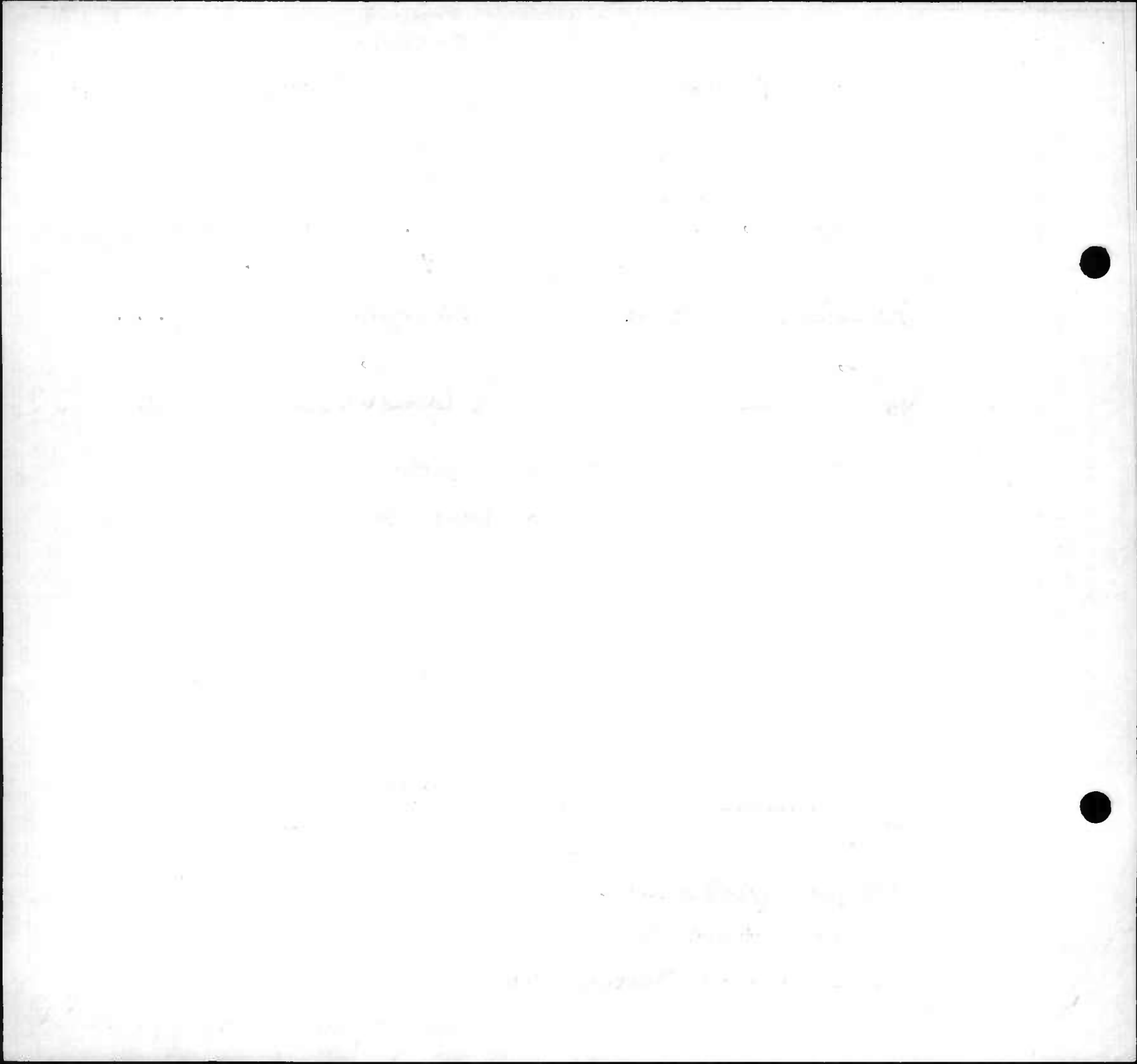
BALTIMORE CITY HEALTH DEPARTMENT REGISTERS									
BIRTH NO. 67 5574		CERTIFICATE OF DEATH ELIZABETH A. COATES 675 5574							
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH 6-3-67 10:20 P. M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND 25-32 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2908 SPELMAN ROAD 21225							
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-1-15	9. AGE (In years last birthday) 51	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME OLIVER COATES			14. MOTHER'S MAIDEN NAME EMMA CEPPERS						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-32-9311		17. INFORMANT Mrs. Constance Foster			ADDRESS 2579 Seamon Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO anemia Chronic renal disease (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 20 years 20+ yrs		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4/15 1967 to 6/3 1967, that (I) (we) last saw the deceased alive on 6/3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Harmon J Eyre				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/3/67			
23C. PHYSICIAN'S NAME (Type) Harmon J Eyre		23D. ADDRESS 601 North Broadway Balt. Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/9/67		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1967		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR WILLIAM C. MARCH		ADDRESS 928 E. NORTH AVE			

20 years
 Chronic renal disease

6/2/02 ✓ Col that probably left	4/12/02 ✓ Col that probably left	6/2/02 ✓ Col that probably left	6/2/02 ✓ Col that probably left	6/2/02 ✓ Col that probably left	6/2/02 ✓ Col that probably left
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

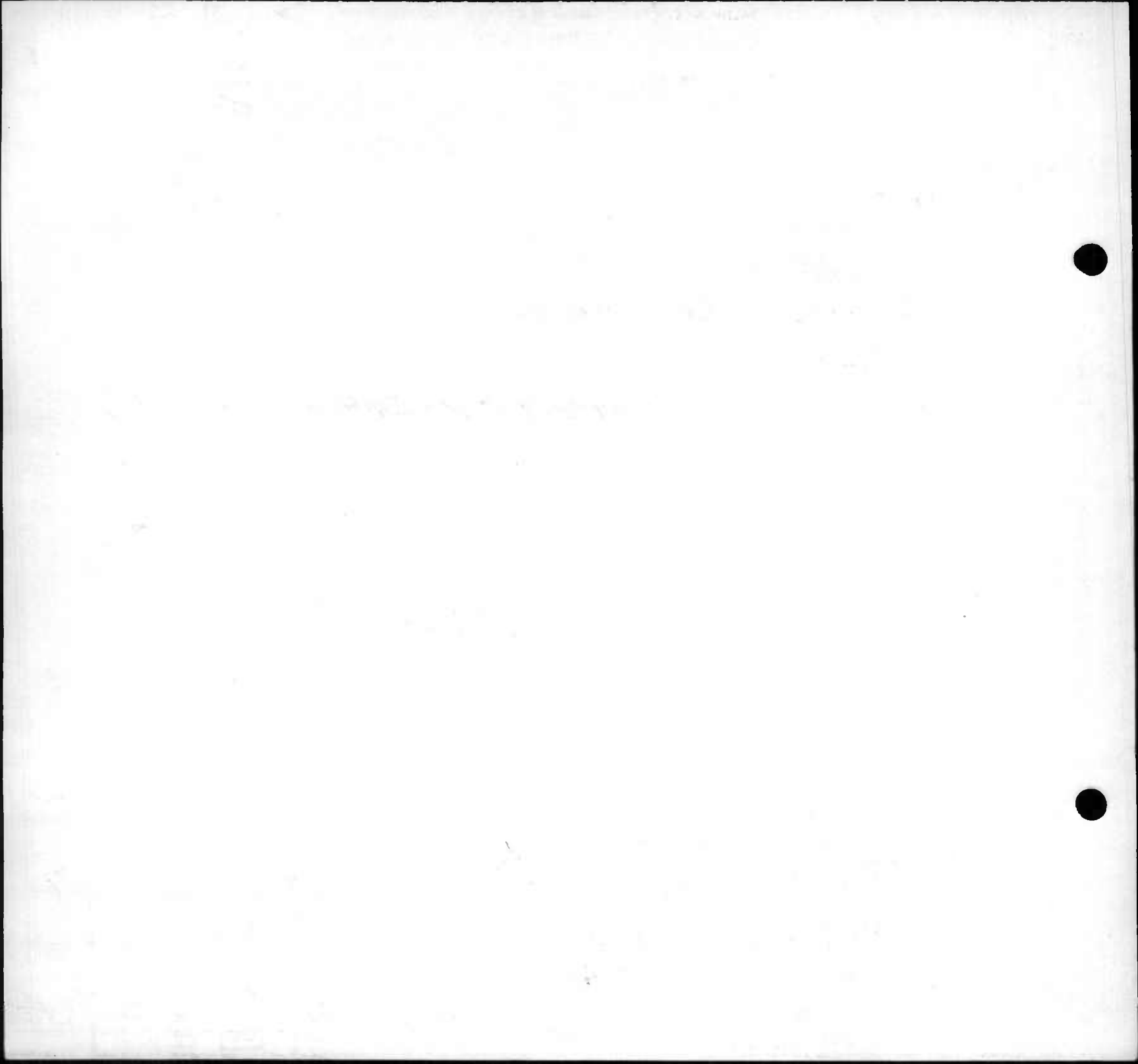
VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

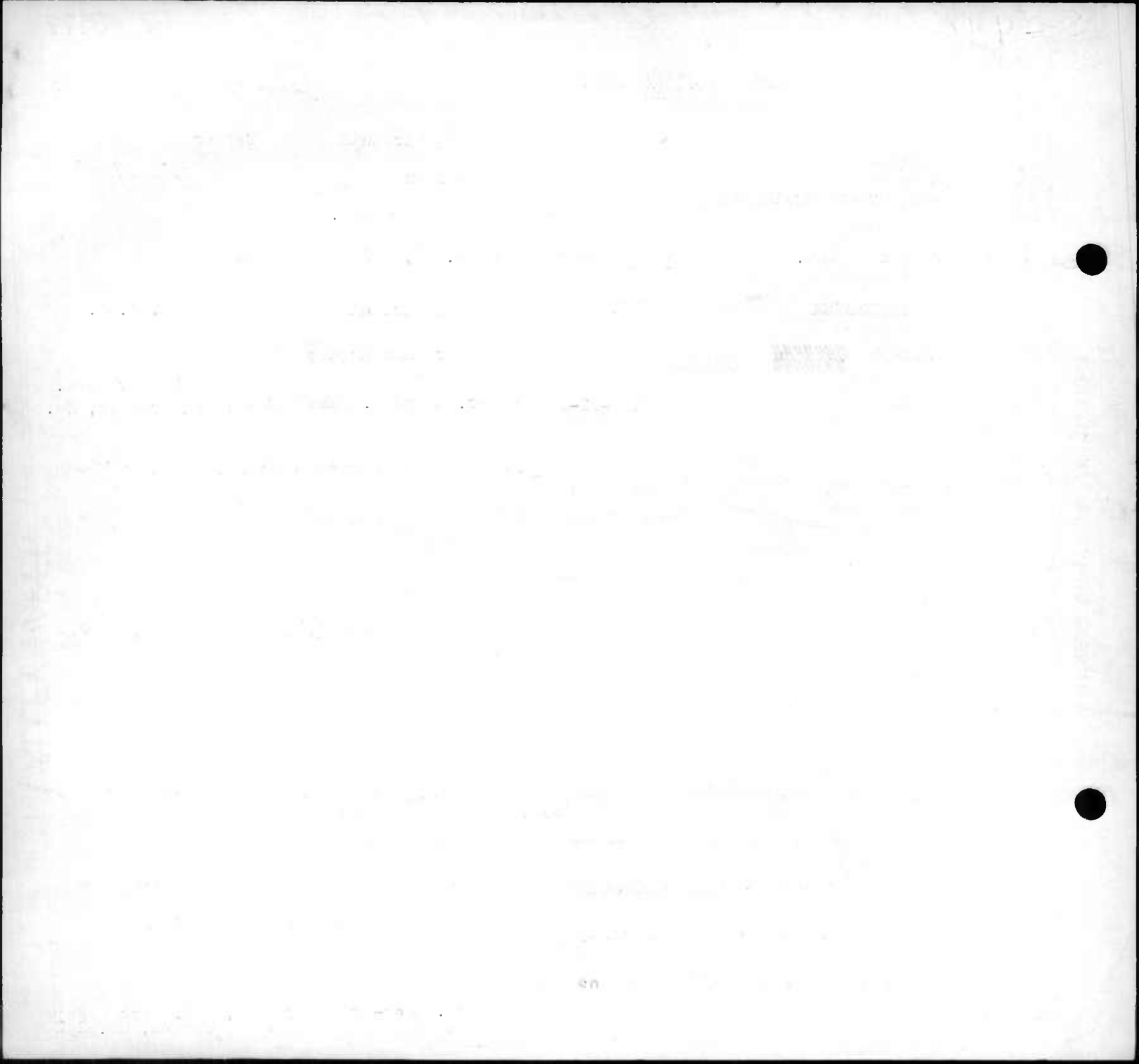
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5576	
BIRTH NO. 67 5576		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Harry Elliott</u>		2. DATE AND HOUR OF DEATH <u>6-5-67 10:30 P.M.</u>	
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>25-32</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>43 South Baltimore General Hosp.</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 21223</u>			
D. STREET ADDRESS (If rural, give location) <u>2617 Carver St.</u>							
5. SEX <u>M.</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>9-15-36</u>	9. AGE (In years last birthday) <u>30</u>	If Under 1 Yr. Months: Ooys		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Gen Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>E/ma Elliott</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>250-54-0054</u>		17. INFORMANT <u>E/ma Elliott 2617 Carver Rd</u> ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PERITONITIS AND SEPSIS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>RETRO PERITONEAL ABSCESS, CECAL</u>				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>PNEUMONIA AND PLEURAL ADHESIONS, RIGHT LUNG.</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from <u>6-5</u> 19 <u>67</u> to <u>6-5</u> 19 <u>67</u> , that the (we) last saw the deceased alive on <u>6-5</u> 19 <u>67</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dr. M. Kauf</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6-6-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. Kaufman, M.D.</u>				23D. ADDRESS <u>1213 Light St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/6/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MO AUBURN</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Thompson & Pagan 638 N. GILMORE ST</u> ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5577		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 5577	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNA GUSEMAN SHACKELFORD		2. DATE AND HOUR OF DEATH Jan 7, 1967 9 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Long Green Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE West Virginia B. COUNTY Taylor C. CITY OR TOWN (If outside city limits, write RURAL and give township) Grafton D. STREET ADDRESS (If rural, give location) 311 Maple Ave.			
5. SEX Female	6. RACE Cau.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH Sept. 16, 1874	9. AGE (In years last birthday) 92	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Joseph GUSEMAN		14. MOTHER'S MAIDEN NAME Mary Ann HAYES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 235-72-6481T		17. INFORMANT Mr. Lloyd G. Shackelford, Lutherville, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 450.11 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Generalized arteriosclerosis (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3+20	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Gangrene of left foot		2 months	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? III in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 3, 1966 to Jan 7, 1967, that (I) (we) last saw the deceased alive on Jan 2, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick J. Vollmer		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Jan 8, 1967	
23C. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER		23D. ADDRESS 6100 YORK RD BALTO. MD 21212			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JUNE 10, 67		24C. NAME OF CEMETERY OR CREMATORY Bluemont Cemetery	
24D. LOCATION Grafton, West Virginia		25A. DATE REC'D BY HEALTH DEPT. JUN 9 1967			
25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR W. Cook-Brooks			
25D. ADDRESS Towson, Md. 21204		25E. ADDRESS Towson, Md. 21204			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 5578		CERTIFICATE OF DEATH		67 5578	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GAIL BORNEFELD		6-9-67 3 ³⁰ -A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
701 Cathedral St Union Men		Md. Baltimore			
5. SEX		6. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		11/16/89		77	
6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		10. CITIZEN OF WHAT COUNTRY?	
white		MARRIED		U.S.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife		Own Home		Fairmont, W.Va.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Thomas H.B. Staggars		Laura Burns			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Charles F. Bornefeld 701 Cathedral St Balt Md	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 I		(A) DUE TO		2 hrs.	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II		Hypertension, severe		7 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1965 to 6-9-1967, that (I) (we) last saw the deceased alive on 6-9-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
William P. Benson, Jr.				6-9-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
WILLIAM P. BENSON, JR.				3506 N. CALVERT, BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Cremation		6/12/67		Greenmount	
24D. LOCATION (City, town, or county)		24E. STATE		24F. ADDRESS	
Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 9 1967		Robert E. Feltz, MD		Wm. Cook-Brooks Inc. Baltimore, Md. 21202	

10-4-61

10-4-61

Mr. J. H. Moore
101 Catherine St
St. Louis, Mo.

Mr. J. H. Moore
101 Catherine St
St. Louis, Mo.

11

Female white mated

Housewife

From home

From home

10-4-61

10

10-4-61

10-4-61

10-4-61

10-4-61

10

BIRTH NO. 67 5579 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5579

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) MILLIE CLARK				2. DATE AND HOUR PRONOUNCED DEAD June 2, 1967 4:31 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 PROVIDENT HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 634 George Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 3/15/1880	9. AGE (In years last birthday) 87	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Red Clark			14. MOTHER'S MAIDEN NAME Jane Lane				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-520783		17. INFORMANT Michael Clark		ADDRESS Same	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/3/67 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/7/67		23C. NAME OF CEMETERY or CREMATORY Mt. Auburn		23D. LOCATION (City, town, or county) (State) Baltimore Md.	
24A. DATE REC'D BY HEALTH DEPT. JUN 9 1967		24B. NAME OF REGISTRAR Robert E. Fagan		24C. FUNERAL DIRECTOR Wilmington Phillips		ADDRESS 1727 N. Monmouth St.	

INITIAL

FOURGE

Wm. F. ...
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A-536

67 5580

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5580

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

CONRAD

R.

ANDERSON

2. DATE AND HOUR PRONOUNCED DEAD

June 2, 1967

1 3:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2518 Druid Hill Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2518 Druid Hill Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

July 27, 1925

9. AGE (in years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Danville, Va

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Conrad Anderson

14. MOTHER'S MAIDEN NAME

Emily Monteleone

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

(Mrs) Gladys McLean 1914 N. Fulton Ave.

18.

795751

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Undetermined

(A) DUE TO advanced decomposition

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/3/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-7-67

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUN 9 1967

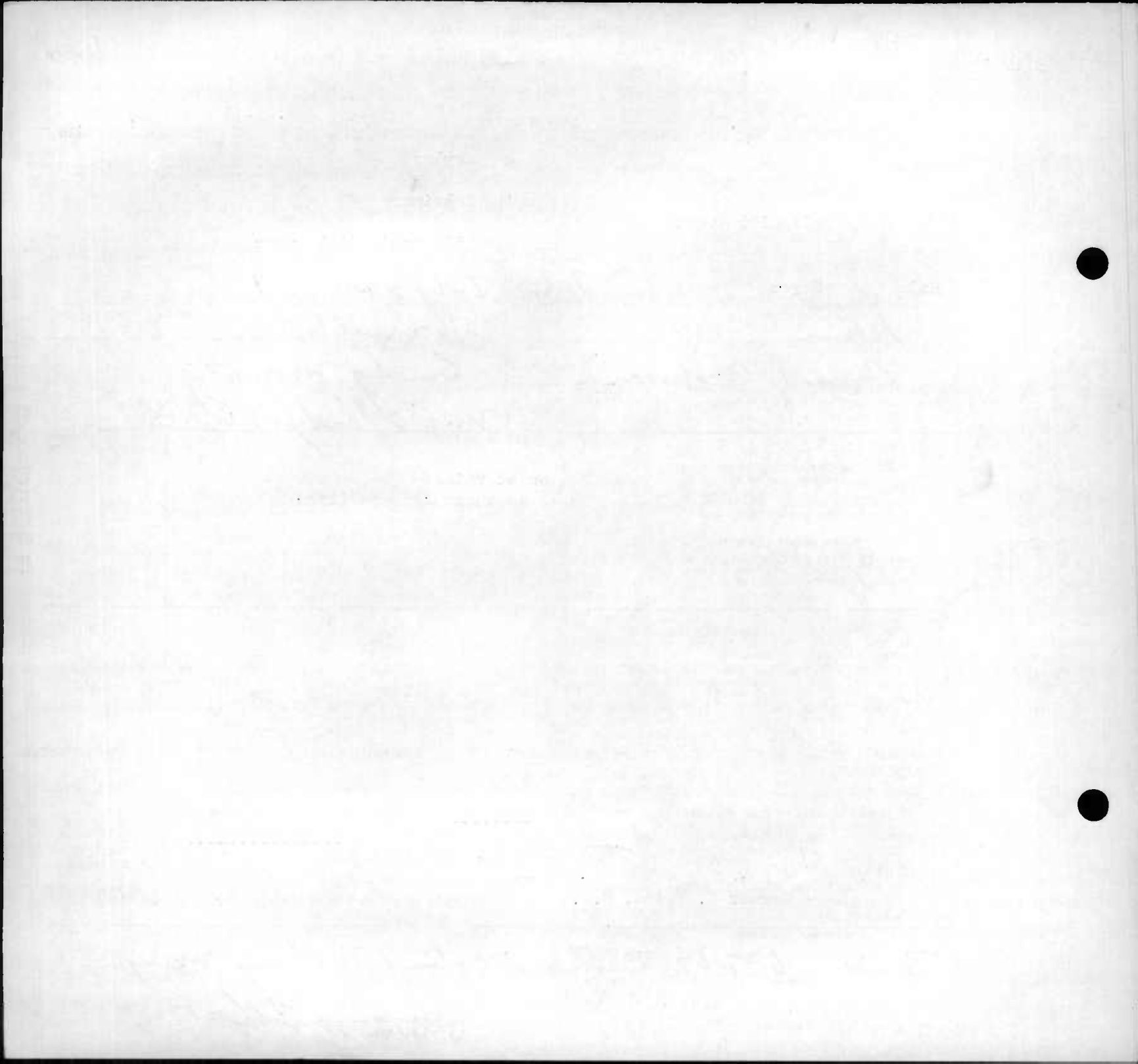
24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

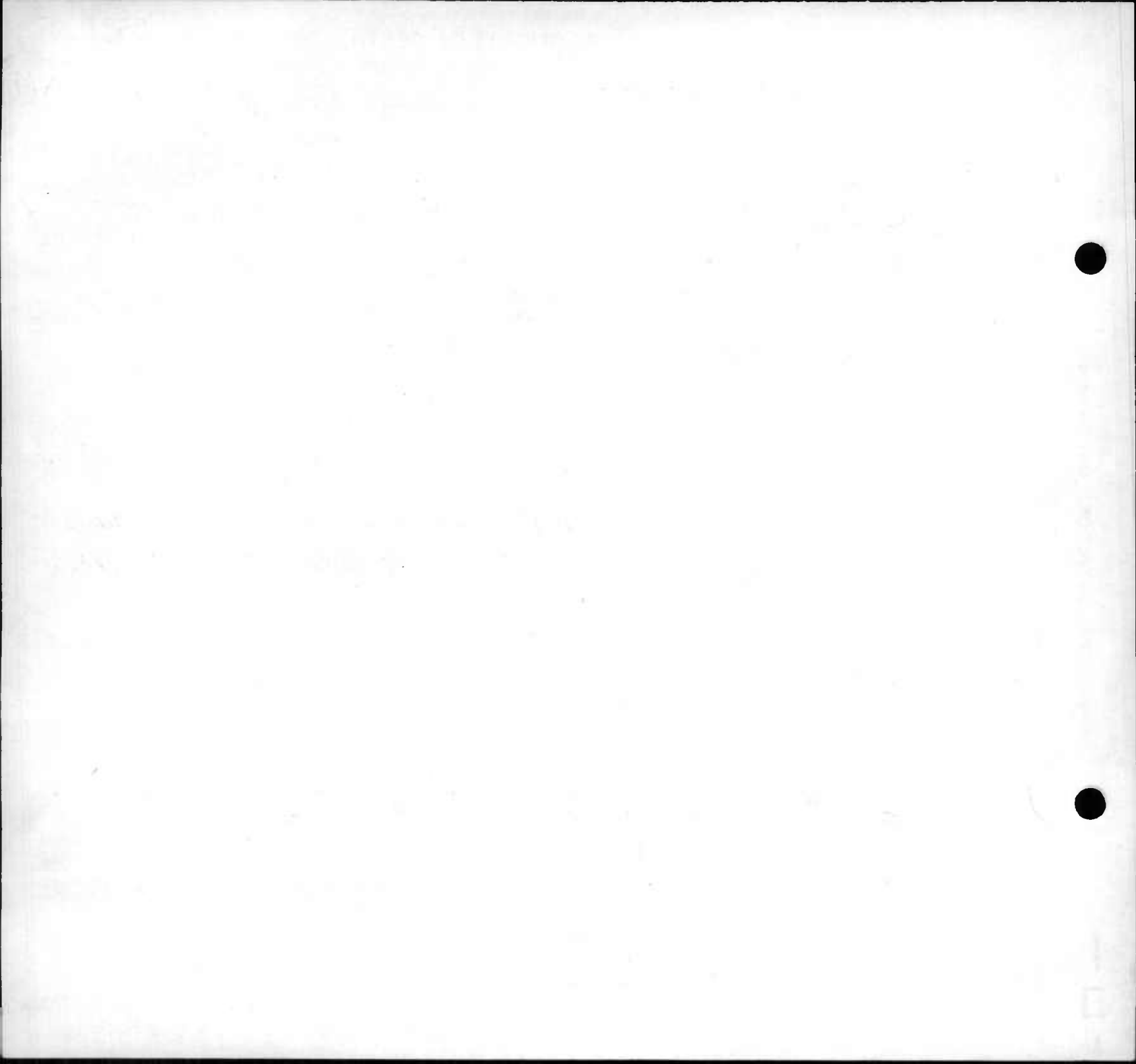
1727 N. name ST.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

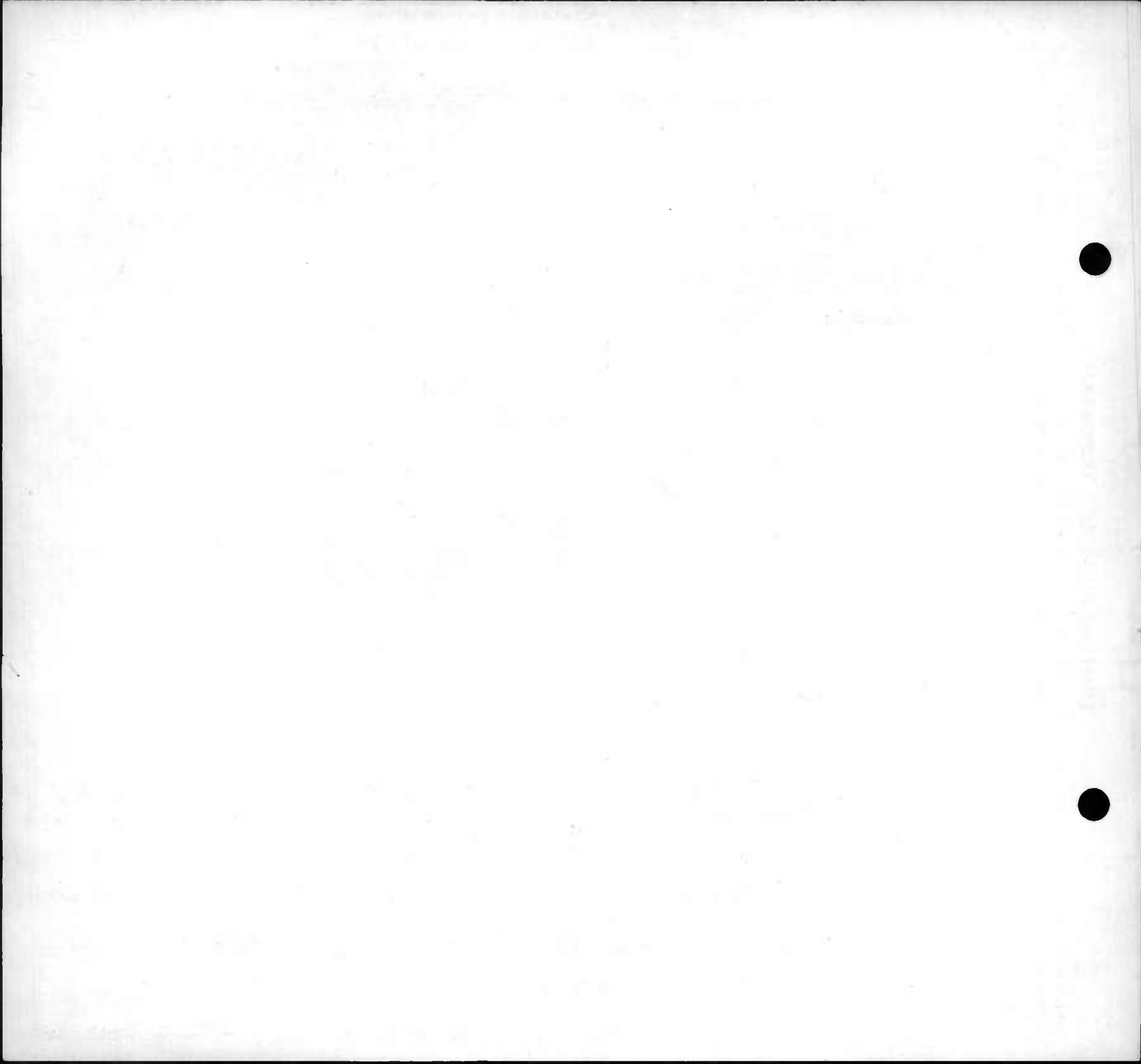
BIRTH NO. 67 5581		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5581	
CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BOBBY WRAGG		2. DATE AND HOUR OF DEATH 6/8/67 9:35 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL 38		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 17-02	
		D. STREET ADDRESS (If rural, give location) 593 OXFORD ST #1			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 5/25/33	9. AGE (In years last birthday) 34	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY FERTILIZER PLANT IN CURTIS BAY		11. BIRTHPLACE (State or foreign country) N.Y.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MAJOR WRAGG		14. MOTHER'S MAIDEN NAME SARAH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —		17. INFORMANT HECHARTAL ADDRESS	
18. 446X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury at complication which caused death.)		(B) MALIGNANT HYPERTENSION DUE TO		~ MONTH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) TERMINAL END-STAGE KIDNEY DUE TO		~ WKS	
		(C) ARTERIOLAR NEPHROSCLEROSIS		72 YRS	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from APRIL 1965 to PRESENT 1967 and that we (we) last saw the deceased alive on 6/8 1967 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did not) view the body after death.					
23A. SIGNATURE Harry D. Plotnick M.D.				23B. DATE SIGNED 6/8/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) 6-12-67 Int Calvary		24B. DATE		24C. NAME OF CEMETERY or CREMATORY Balto. Int	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Howe ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5582</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>67 5582</u>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>Knyght, Katherine (Harris)</u>		2. DATE AND HOUR OF DEATH <u>6/7/67</u> <u>10 55</u> <u>A</u> . M.			
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>16-03</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>1001 North Mount St.</u>			
5. SEX <u>Fe.</u>	6. RACE <u>Mar.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6/12/07</u>	9. AGE (In years lost birthday) <u>58</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chart</u> ADDRESS	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Acute Myocardial Infarction. Cor.</u> (B) <u>ISCVD.</u> (C)		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>6/7/67</u> 19 to <u>6/7/67</u> that (I) (we) last saw the deceased alive on <u>6/7/67</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Erwin H. Hesselberg</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/7/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Erwin H. Hesselberg</u>		M.D. ADDRESS <u>Sinai Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/9/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>A A County Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 9 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Talbot</u>	
25C. FUNERAL DIRECTOR <u>Edo Ehus Halstead</u>		ADDRESS <u>1206 W North Av</u>			

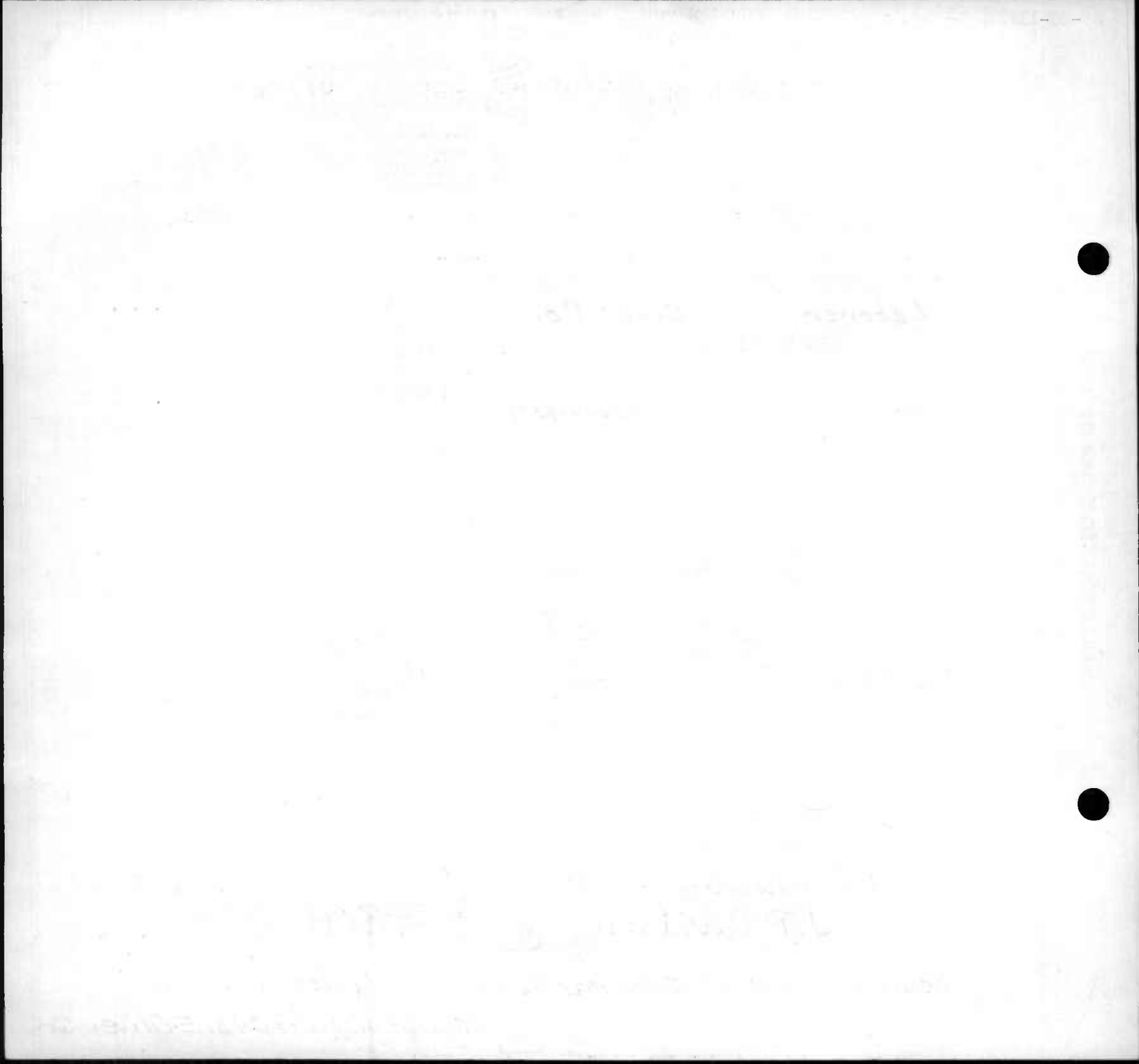


CERTIFICATE OF DEATH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BIRTH NO. 67 5583		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 5583	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Fleming, Charles Lee</i>		2. DATE AND HOUR OF DEATH <i>6/7/67 11:15 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 8-05</i> D. STREET ADDRESS (If rural, give location) <i>1806 N. CHESTER STREET 21213</i>			
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>3-10-24</i>	9. AGE (In years last birthday) <i>43</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Steel Co.</i>		11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i>			
13. FATHER'S NAME <i>ERNEST FLEMING</i>				14. MOTHER'S MAIDEN NAME <i>LUCY RANDOLPH</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-14-4577</i>		17. INFORMANT <i>BCH: RECORDS 4940 EASTERN AVE. 21224</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Hepatic coma</i> DUE TO <i>Alcoholic cirrhosis</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>GI hemorrhage</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6/7</i> 19 <i>67</i> to <i>6/7</i> 19 <i>67</i> , that (I) (we) lost saw the deceased alive on <i>6/7</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J.T. Davidson</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/7/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>J.T. Davidson</i>				23D. ADDRESS <i>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO. MD. 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>6-10-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Saint Mark Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Louisa Co., Va</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 9 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Randolph J. Collick</i>		ADDRESS <i>2431 E. Oliver St.</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-10889		CERTIFICATE OF DEATH		Registered No. 3584	
1. NAME OF DECEASED (Type or Print) BABY BOY ASHE		2. DATE AND HOUR OF DEATH 6-5-67 2:23 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, give RURAL and give township) BALTIMORE 20-01 D. STREET ADDRESS (If rural, give location) 1946 PENROSE AVENUE 21223			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEONATE	8. DATE OF BIRTH 6-5-67	9. AGE (In years last birthday) 14 yrs 3 mo	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 14 3
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME GARLAND ASHE		14. MOTHER'S MAIDEN NAME THELMA ASHE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT CHART - ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Rb massive intracranial hemorrhage. (B) DUE TO ? possible clotting disturbance (C) ? trauma		INTERVAL BETWEEN ONSET AND DEATH ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. prematurity					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-5-1967 to 6-5-1967, that (I) (we) lost saw the deceased alive on 6-5-1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E Mc Hugh		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> HOUSE		23B. DATE SIGNED 6-5-67	
23C. PHYSICIAN'S NAME (Type) DR. E. MC HUGH		23D. ADDRESS Baltimore City Hospital BALTO. 21224, MD 4940 EASTERN			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 6-6-67		24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals	
24D. LOCATION Baltimore, Maryland 21224					
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR R. B. E. Fisher, M.D.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL	
ADDRESS					

FUNERAL DIRECTOR: IMPORTANT

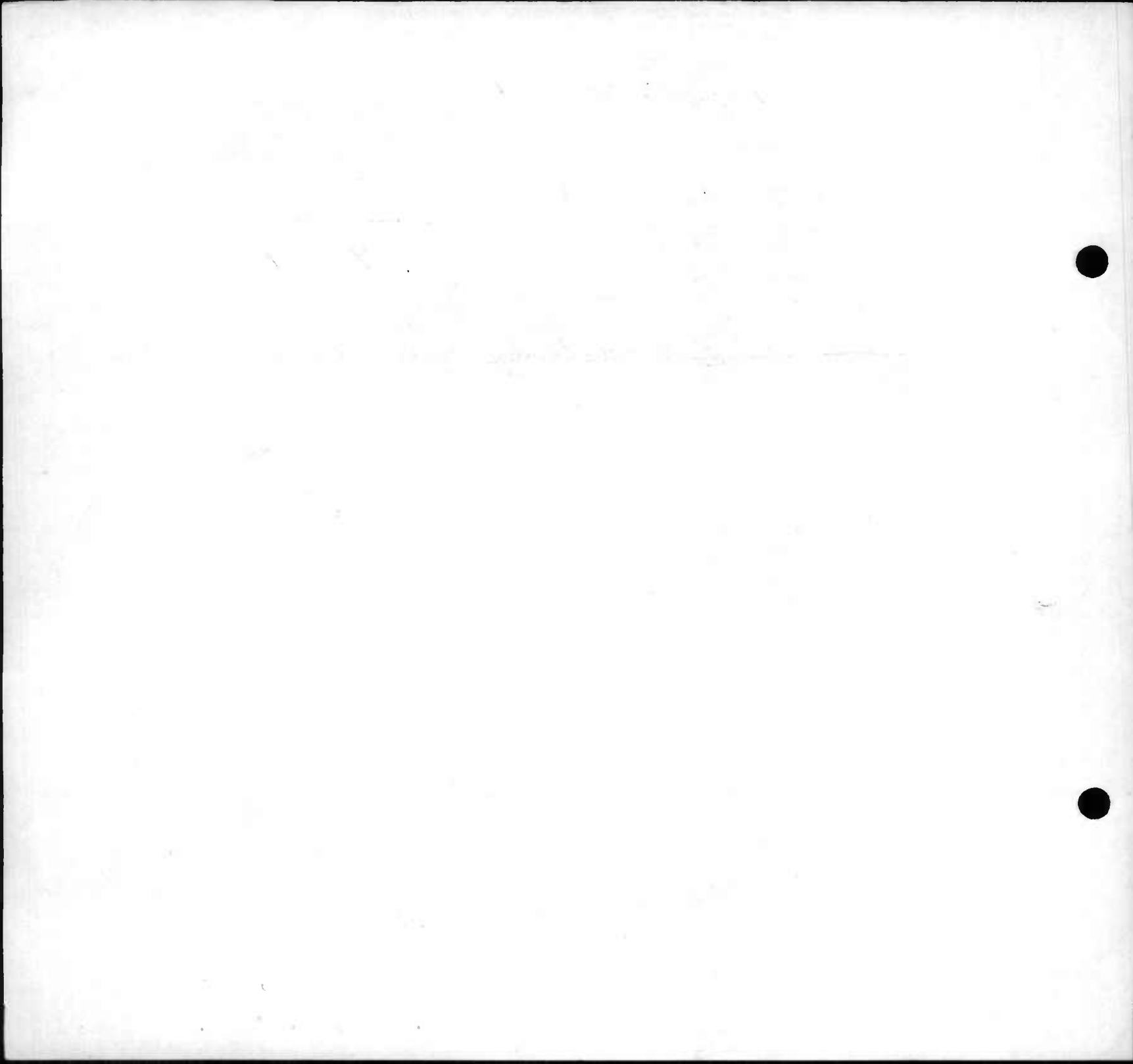
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5585	
BIRTH NO. 67 5585		CERTIFICATE OF DEATH		Registered No. 67 5585	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) NORMA BAUER		2. DATE AND HOUR OF DEATH 6/8/67 7 05 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 6-01	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33		D. STREET ADDRESS (If rural, give location) 124 N. DECKER AVE 21224			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED DIVORCED	8. DATE OF BIRTH 05-11-11	9. AGE (In years last birthday) 56	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LEVI PAYNE		14. MOTHER'S MAIDEN NAME VICTORIA PEAK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown		17. INFORMANT ADDRESS Mrs. Sandra Boyce 1305 S. Anglesea St	
18. 410X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CARDIAC ARREST (B) RHEUMATIC HEART DISEASE (C) 6 WKS POST-MITRAL VALVE REPLACEMENT		INTERVAL BETWEEN ONSET AND DEATH 1 HRS 12 YRS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PULM. HYPERTENSION				YRS.	
19A. DATE OF OPERATION 4-24-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RHEUMATIC HEART DISEASE		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 4/4 1967 to 6/8 1967, that (I) (we) last saw the deceased alive on 6/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Don Eugene Detmer		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/8/67	
23C. PHYSICIAN'S NAME (Type) DON EUGENE DETMER		23D. ADDRESS M.D. JOHNS HOPKINS HOSP. BALTO, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/67		24C. NAME OF CEMETERY OR CREMATORY Crest Lawn Gardens of Memories, Baltimore, Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Feltz	
25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 5586		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5586	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) MOYLAN, ISABELLE ROSILIA			
2. PLACE OF DEATH IN BALTIMORE, MARYLAND				3. DATE AND HOUR OF DEATH JUNE 8, 1967 9:00 AM.			
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 5 N. EAST AVE.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/20/98	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A
13. FATHER'S NAME FRANK WENDEL GEORGE BRUNGE				14. MOTHER'S MAIDEN NAME PERCY BELLE WENDEL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216 09 6243		17. INFORMANT ADDRESS DANIEL J. MOYLAN 5 N. EAST AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (Post operative) ulceration colitis & pneumonia				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 mos. 30 days.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0722.21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MARCH 31 19 67 to JUNE 8 19 67 , that (I) (we) last saw the deceased alive on JUNE 8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Chull H. Lee				M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED JUNE 8-67	
23C. PHYSICIAN'S NAME (Type) CHULL H. LEE				23D. ADDRESS M.O. Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Creation		24B. DATE 6/12/67		24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR JOHN E. MORAN, Inc.		25C. FUNERAL DIRECTOR JOHN E. MORAN, Inc.		ADDRESS 3000 E. Baltimore St	



CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)~~JOHN F. FALTER~~ J. Francis Falter

2. DATE AND HOUR OF DEATH

6/7/67

9:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

16 N. East Avenue #21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

7-23-09

9. AGE (In years
last birthday)

57

If Under 1 Yr.
Months: Days: Hours: Min.If Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John F. Falter

14. MOTHER'S MAIDEN NAME

Agnes Miller

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL
SECURITY NO.

212-10-8013

17. INFORMANT

RECORDS:

BCN 4940 Eastern Avenue
Baltimore, Maryland #21224

18. 163 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

CARCINOMA of Lung 3 mos

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 14 19 67 to June 7 19 67
that (I) (we) last saw the deceased alive on June 7 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6/7/1967

23C. PHYSICIAN'S
NAME (Type)

STUART SILVER

23D. ADDRESS

M.D.

4940 Eastern Avenue Baltimore, Md. #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)
Burial

24B. DATE

6/10/67

24C. NAME of CEMETERY or CREMATORY

New Cathedral Cem.

24D. LOCATION

(City, town, or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 12 1967

25B. NAME OF REGISTRAR

Robert E. Starkey, M.D.

25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. Md.

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

12/1/74

12/1/74

12/1/74

12/1/74

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12/1/74

12/1/74

12/1/74

12/1/74

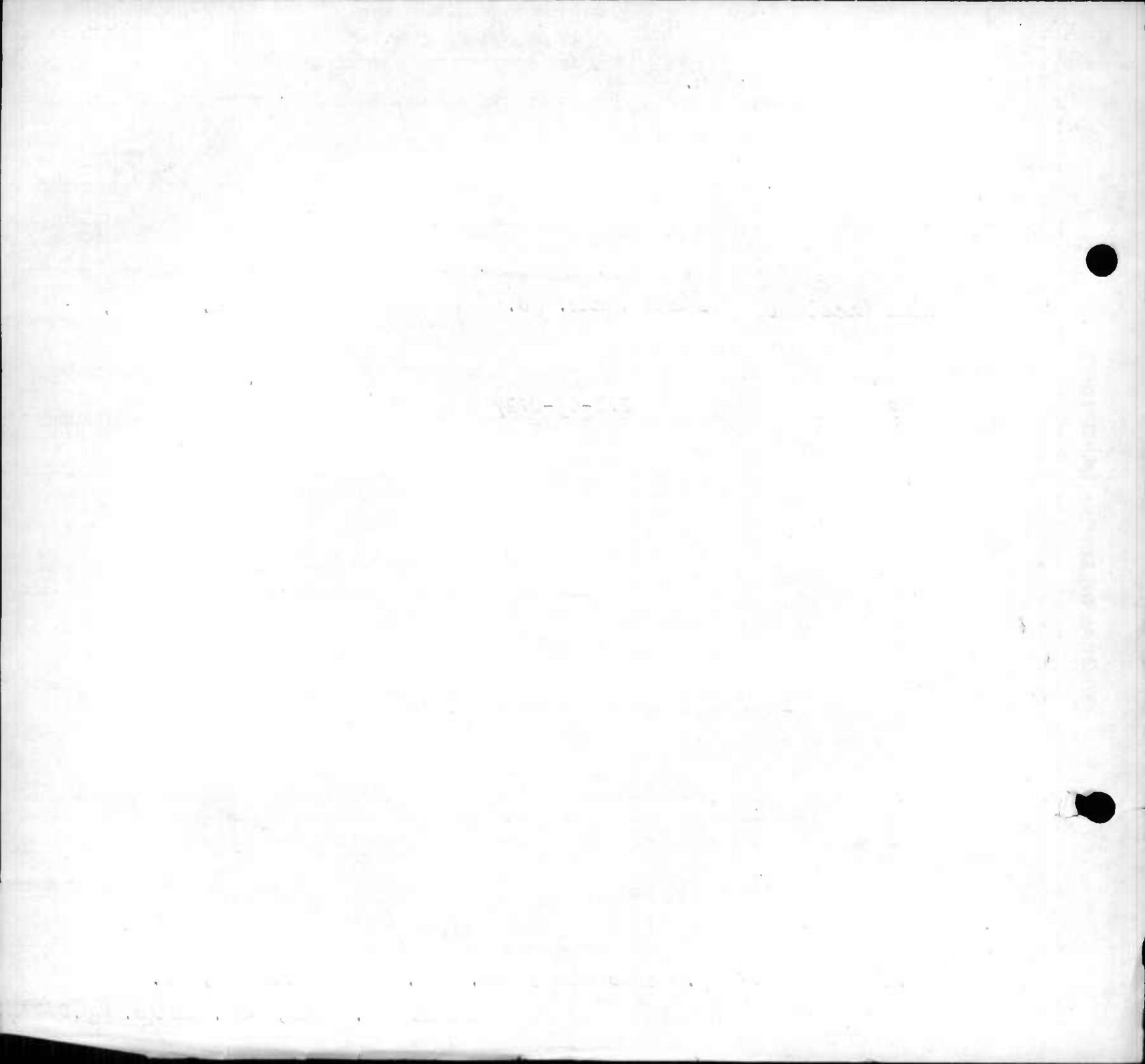
12/1/74

12/1/74

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5588	
BIRTH NO. 67 5588		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BERNARD H. WAYS		2. DATE AND HOUR OF DEATH 6-8-67 5:44 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-38	
		D. STREET ADDRESS (If rural, give location) 1520 WAVERLY WAY			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-24-08	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President		10B. KIND OF BUSINESS OR INDUSTRY Fleet Trans. Co.		11. BIRTHPLACE (State or foreign country) BALTIMORE Md.	
13. FATHER'S NAME ROLAND WAYS		14. MOTHER'S MAIDEN NAME ELIZABETH HAMPTON		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-03-0127		17. INFORMANT DETTA WAYS ADDRESS S/A	
18. 163 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Metastatic neoplasm Renal cell Ca Adenocarcinoma of Lung Bronchopneumonia		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-26-67 to 6-8-1967 , that (I) (we) last saw the deceased alive on 6-8-1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Timothy K. Gray M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-8-67	
23C. PHYSICIAN'S NAME (Type) TIMOTHY K. GRAY M.D.		23D. ADDRESS Maryland General Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/13/67		24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Cem.	
		24D. LOCATION (City, town, or county) (State) Elkridge, Md.			
25A. DATE RECEIVED JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. ADDRESS 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 5589 CERTIFICATE OF DEATH					Registered No. 67 5589					
BIRTH NO.					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Theodore C. REYERSON, Sr.</i>					2. DATE AND HOUR OF DEATH <i>6-8-67 2⁰⁵ pm.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <i>49 NORTH CHARLES General Hospital</i>					A. STATE <i>Md.</i> B. COUNTY <i>5-05</i>					
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE Md.</i>					D. STREET ADDRESS (If rural, give location) <i>1749 CHFTVIEW AV. - 21213</i>					
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>1-6-83</i>	9. AGE (In years last birthday) <i>84</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Unknown</i>					14. MOTHER'S MAIDEN NAME <i>- Unknown</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No -</i>			16. SOCIAL SECURITY NO. <i>Unk.</i>		17. INFORMANT <i>John REYERSON - (son)</i>			ADDRESS <i>605 - Foxcroft Dr.</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>153.8 I METASTATIC CARCINOMA</i>					INTERVAL BETWEEN ONSET AND DEATH <i>4-23-67</i>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO <i>CA of the colon</i> (B) DUE TO <i>-</i> (C) DUE TO <i>-</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <i>0 -</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>4-23-67</i> 19 to <i>6-8-</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6-8-</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>2⁰⁵ pm.</i>										
23A. SIGNATURE <i>Luis E. Reyel</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>6-8-67</i>		
23C. PHYSICIAN'S NAME (Type) <i>Ralph - Mostwill</i>					23D. ADDRESS <i>1801 Eutaw Rd. 21222</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>6/12/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 12 1967</i>			25B. NAME OF REGISTRAR <i>Robert E. Talley</i>			25C. FUNERAL DIRECTOR <i>Leonard Y. Ruck, Inc. Balto.</i>			ADDRESS <i>Md. 21214</i>	

1801 E. 4th St. 51275

K-414

67 5590

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5590

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)LEONARD ~~Kalbfleisch~~ **H. Kalbfleisch**

2. DATE AND HOUR PRONOUNCED DEAD

June 8, 1967

3:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2600 E. Monument Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2600 E. Monument Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Mar. 18, 1911

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Tavern Owner

10B. KIND OF BUSINESS OR INDUSTRY

Tavern

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Charles Kalbfleisch

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

212-01-6851

17. INFORMANT

Mrs. Isabel Kalbfleisch

ADDRESS

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Contact gunshot wound of head

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

bar

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2600 East Monument Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6-8-67 2:30 A.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 8, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

23B. DATE

6/12/67

23C. NAME of CEMETERY or CREMATORY

Greenmount Cem.

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 12 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. Md.

ADDRESS

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5591	
BIRTH NO. 67 5591		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Hopkins, Mary Virginia			
2. DATE AND HOUR OF DEATH 6/8/67 3:25 pm		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3100 St. Paul St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 12/21/97	9. AGE (In years last birthday) 69	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher - retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Education	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Hopkins, Robert H.		14. MOTHER'S MAIDEN NAME M. Bennett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-40-4758		17. INFORMANT ADDRESS Hospital Records - Md. Gen. Hosp.	
18. 153.8 I		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH 9 mo.
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Adenocarcinoma of Colon with metastases DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/7 19 67 to 6/8 19 67, that (I) (we) last saw the deceased alive on 6/8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rolph M. Sabundayo				23B. DATE SIGNED June 8, 1967	
23C. PHYSICIAN'S NAME (Type) ROLPH M. SABUNDAYO				23D. ADDRESS Maryland Gen. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/1967		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			
25B. NAME OF REGISTRAR Rolph M. Sabundayo		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore, Md. 21212			

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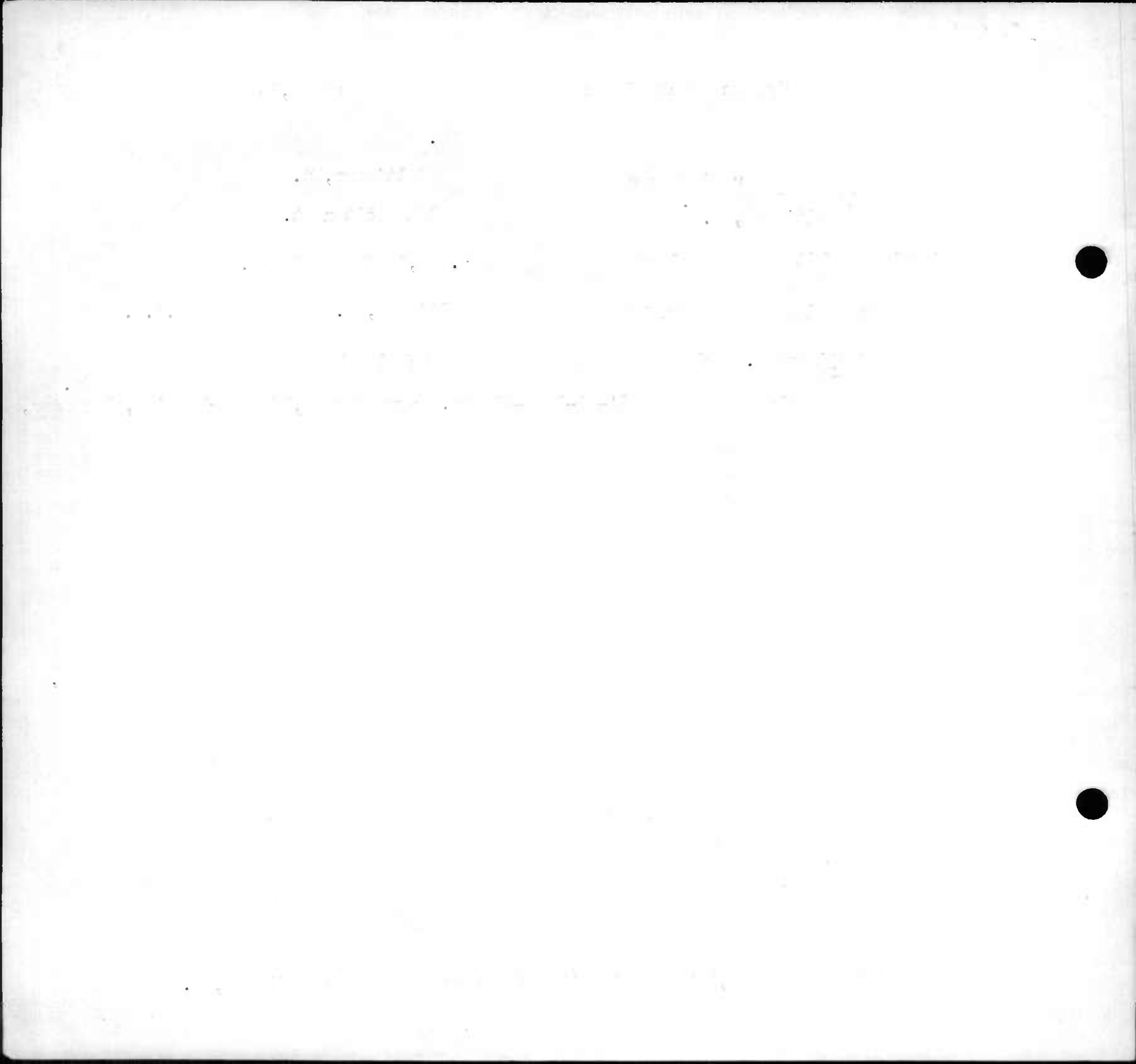
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5592	
BIRTH NO. 67 5592		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Florence Focke Jones		2. DATE AND HOUR OF DEATH June 6, 1967 7:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Long Green Nursing Home 115 E Melrose Ave. Baltimore, Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Md.		D. STREET ADDRESS (If rural, give location) 1716 Baltom St.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Jan. 20, 1882	9. AGE (In years lost birthday) 85 yrs.	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ferdinand D. Focke		14. MOTHER'S MAIDEN NAME Rachel Lehman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO None		16. SOCIAL SECURITY NO. 214-03-3390-J1		17. INFORMANT ADDRESS Mrs. Wayne Kenney, 3726 Mark Drive, Alexander, Va.	
18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Interaschosis, generalized		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1956 to June 6, 1967, and that (we) last saw the deceased alive on June 4, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William H. Efrich M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 7, 1967			
23C. PHYSICIAN'S NAME (Type) WILLIAM HEFRICH		23D. ADDRESS 5006 ROWAN AVE. BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 6, 1967		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION Pikesville 8 Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Fackey	
25C. FUNERAL DIRECTOR James H. Hemell		25D. ADDRESS Pikesville 8 Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5593	
BIRTH NO. 67 5593		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CAMPBELL, JAMES HUDSON			
2. DATE AND HOUR OF DEATH 6/3/67 2:40 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MARYLAND			
D. STREET ADDRESS (If rural, give location) 1439 HUBERT STREET		5. SEX MALE 6. RACE CAUCASION 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED			
8. DATE OF BIRTH 7/16/21 9. AGE (In years last birthday) 45		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10B. KIND OF BUSINESS OR INDUSTRY Proctor & Gamble	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HUDSON CAMPBELL		14. MOTHER'S MAIDEN NAME CHARLOTTE SHECKELS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 2/9/42 to 11/11/45		16. SOCIAL SECURITY NO. 219-07-5535		17. INFORMANT RECORDS V.A.H. BALTIMORE, MARYLAND 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH HEPATIC COMA (This does not mean the mode of dying, e.g., heart failure, osteomyelitis, etc. It means the disease, injury or complication which caused death.) LAENNEC'S CIRRHOSIS		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 Weeks Years	
19. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 25 19 67 to JUNE 3 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 3 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.		23A. SIGNATURE Domingo A. Garcia		23B. DATE SIGNED 6-3-67	
23C. PHYSICIAN'S NAME (Type) Domingo A. Garcia		23D. ADDRESS V.A. HOSPITAL 3900 LOCH RAVEN BLVD., BALTIMORE, MD. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 7, '67		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR George J. Gonce	
25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hgwy., Baltimore			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5594				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5594	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
SAMUEL O. SUSEL				2. DATE AND HOUR OF DEATH JUNE 6, 1967 2:18 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 3000 W. GARRISON AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JAN. 14, 1908	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR		10B. KIND OF BUSINESS OR INDUSTRY GROCERY STORE		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISAAC SUSEL				14. MOTHER'S MAIDEN NAME ESTHER DECKELBUAM			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MRS. RUTH SUSEL, 3000 W. GARRISON AVENUE		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.1 + 1260X				CAUSE OF DEATH (A) Myocardial Infarction (B) Hypertensive Arteriosclerosis (C) Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Diabetes Mellitus							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (We) (hospital) attended the deceased from 11-14-1967 to 6-6-1967, that (I) (We) last saw the deceased alive on 5-15-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph Deckelbaum				23B. DATE SIGNED 6-6-67			
23C. PHYSICIAN'S NAME (Type) JOSEPH DECKELBAUM				23D. ADDRESS M.D. 3502 West Rogers Ave. Balto. Md. 21215			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/7/67		24C. NAME of CEMETERY or CREMATORY KNESSETH ISRAEL KOLK WOLYN		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.		ADDRESS 6010 REIST., RD.	

11



BALTIMORE CITY HEALTH DEPARTMENT

67 5595

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 5595

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIE

KELLER

2. DATE AND HOUR PRONOUNCED DEAD

June 8, 1967

7:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1225 N. CAROLINE STREET

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1225 N. Caroline Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Jan 27, 1927

9. AGE (in years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Lie Co.

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Keller

14. MOTHER'S MAIDEN NAME

Fannie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Ernestine Keller - 1772 Castle St.

18.

581.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Fatty alteration of liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

6/8/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/14/67

23C. NAME of CEMETERY or CREMATORY

Wt. Auburn Cem

23D. LOCATION

Balto.

(City, town, or county)

(State)

Managers

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 12 1967

Robert E. Farber

Earl Helms

1827 W. North Ave

FOUR

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.						DECEASED						REGISTERED No.														
M.E. CASE NO.																										
1. NAME OF DECEASED (Type or Print)									2. DATE AND HOUR OF DEATH																	
Nehemiah Haughton									6- 8 -67 11:30 P.M.																	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND									4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY																	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)									C. CITY OR TOWN (If outside city limits, write RURAL and give township)																	
1515 N. Bruce St. La Plaza Nursing Home									Maryland Baltimore 14-02 D. STREET ADDRESS (If rural, give location) 1431 Madison Avenue																	
5. SEX			6. RACE			7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH			9. AGE (In years last birthday)			If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.											
Male			Negroid			widowed			11-27-92			74														
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)									10B. KIND OF BUSINESS OR INDUSTRY									11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
																		North Carolina			U.S.A.					
13. FATHER'S NAME									14. MOTHER'S MAIDEN NAME																	
Albert Haughton																										
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)									16. SOCIAL SECURITY NO.			17. INFORMANT						ADDRESS								
Yes WWI									217056945			Annie Haughton 1431 Madison Avenue														
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO									INTERVAL BETWEEN ONSET AND DEATH								
334-X I Myocardial degeneration 1966 Coronary arteriosclerosis 1950 Petit & Jean Paul Convulsions 1965																										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																										
19A. DATE OF OPERATION						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED						20A. AUTOPSY? (Yes or No)						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)						21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)														
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)						21E. INJURY OCCURRED While At Work Not While At Work						21F. HOW DID INJURY OCCUR?														
22. I certify that (I) (this hospital) attended the deceased from July 65 19 to June 8 1967, that (I) (we) last saw the deceased alive on June 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																										
23A. SIGNATURE GEO. H. PENDLETON M.D.												23B. DATE SIGNED														
23C. PHYSICIAN'S NAME (Type)												23D. ADDRESS														
GEO. H. PENDLETON M.D.												1723 Duval Hill														
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)														
Burial				6-12-67				Baltimore, Nat'l. Cem.				Baltimore, Maryland														
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR				ADDRESS														
JUN 12 1967				H. A. Taylor				Kelson Funeral Home				1348 Calhoun St														

ZWW 254

67 5597

BALTIMORE CITY HEALTH DEPARTMENT

67 5597

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Sallie

FRANKLIN

2. DATE AND HOUR PRONOUNCED DEAD

June 8, 1967

2:00 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

306 N. BRUCE STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

306 N. Bruce Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

8-18-80

9. AGE (In years
last birthday)

86

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Edward Franklin 306 Bruce St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic Cardiovascular Disease

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

6/8/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-12-67

23C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

23D. LOCATION

Balto.

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 12 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Kelson Funeral Home 1348 Calhoun St.

ADDRESS

NAVY DEPARTMENT

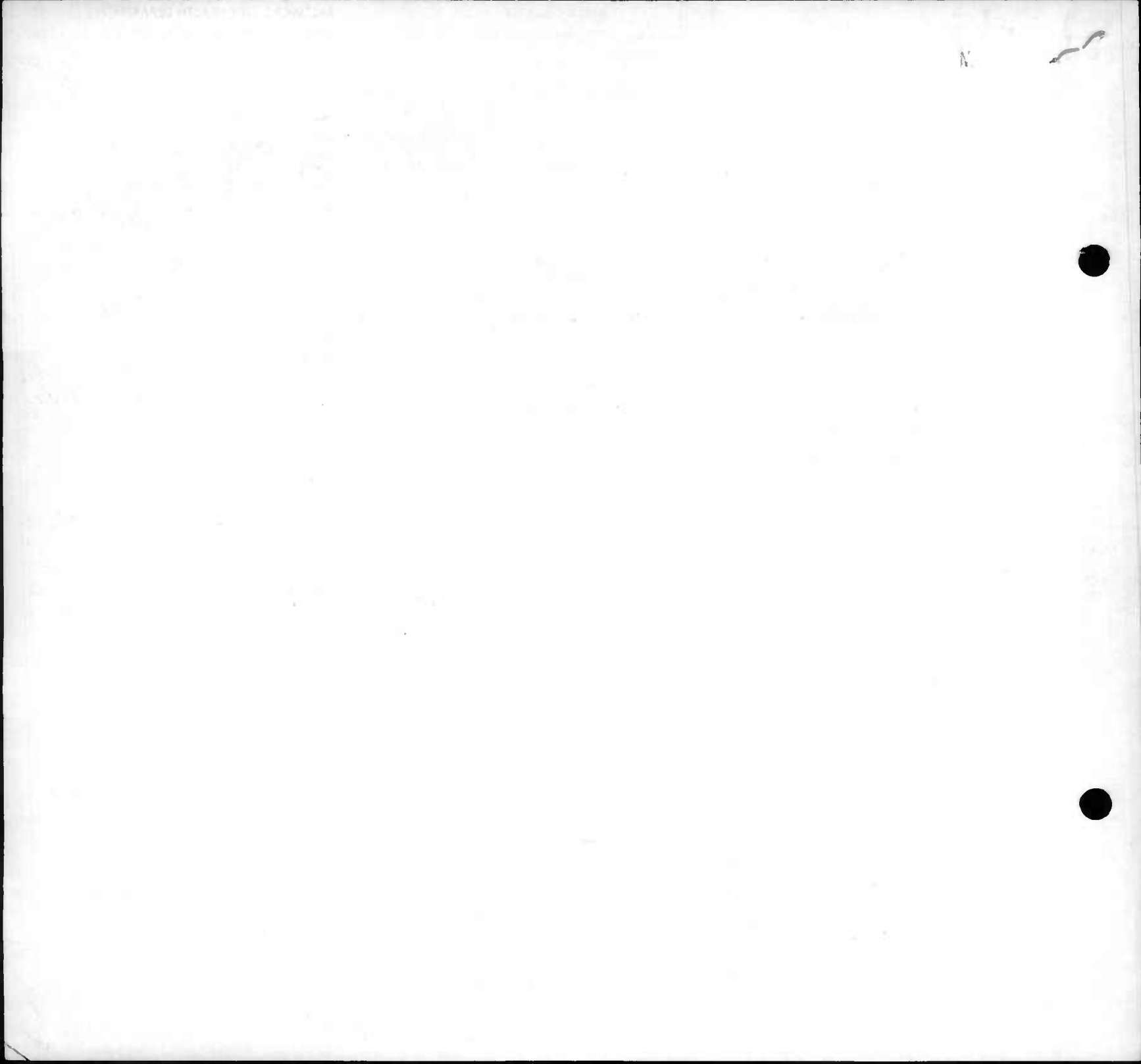
WILLIAM L. BRYAN

NAVY DEPARTMENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5598	
BIRTH NO. Jamestown, N.Y. 67 5598							
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Samuel Perlstein		2. DATE AND HOUR OF DEATH June 7, 1967 6 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital				A. STATE Maryland B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 6520 Eberle Drive apt 203			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 71	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor			10B. KIND OF BUSINESS OR INDUSTRY Internal Revenue		11. BIRTHPLACE (State or foreign country) Jamestown, NY		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Isaac Perlstein				14. MOTHER'S MAIDEN NAME Anna Heller			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 577-40-9419		17. INFORMANT Mrs Pearl Perlstein ADDRESS apt 203 6520 Eberle Dr			
18. 420.14-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.)				CAUSE OF DEATH			
				(A) DUE TO Myocardial Infarct		INTERVAL BETWEEN ONSET AND DEATH Sudden	
ANTECEDENT CAUSES				(B) DUE TO Coronary Sclerotic Heart Disease		2 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Diabetes mellitus		12 years	
				Periphagus Vulgaris		6 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 16 1966 to June 7 1967, that (I) (was) lost saw the deceased alive on June 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) did not view the body after death.							
23A. SIGNATURE Charles E Shaw M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/8/67	
23C. PHYSICIAN'S NAME (Type) CHARLES SHAW				23D. ADDRESS 607 W. TOPPA Rd			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		June 9/67		B'nai B'rith		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Seligman		ADDRESS Rte - 6010 Reut. Rd.	



67 5599

BALTIMORE CITY HEALTH DEPARTMENT

67 5599

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

AUGUST

PHILHOWER

2. DATE AND HOUR PRONOUNCED DEAD

6-10-67

12:15 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

LUTHERAN HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2756 The Alameda

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

April 14, 1905

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

City worker

10B. KIND OF BUSINESS OR INDUSTRY

Sanitation Dept

11. BIRTHPLACE (State or foreign country)

Newark New Jersey

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Henry Philhower

14. MOTHER'S MAIDEN NAME

Anna Bruen

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

218-10-7192

17. INFORMANT

Mrs Alphonsa Philhower

ADDRESS

2756 The Alameda

18. 4221 L 1260 X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Arteriosclerotic cardiovascular disease
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

6-11-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/13/1967

23C. NAME OF CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

JUN 12 1967

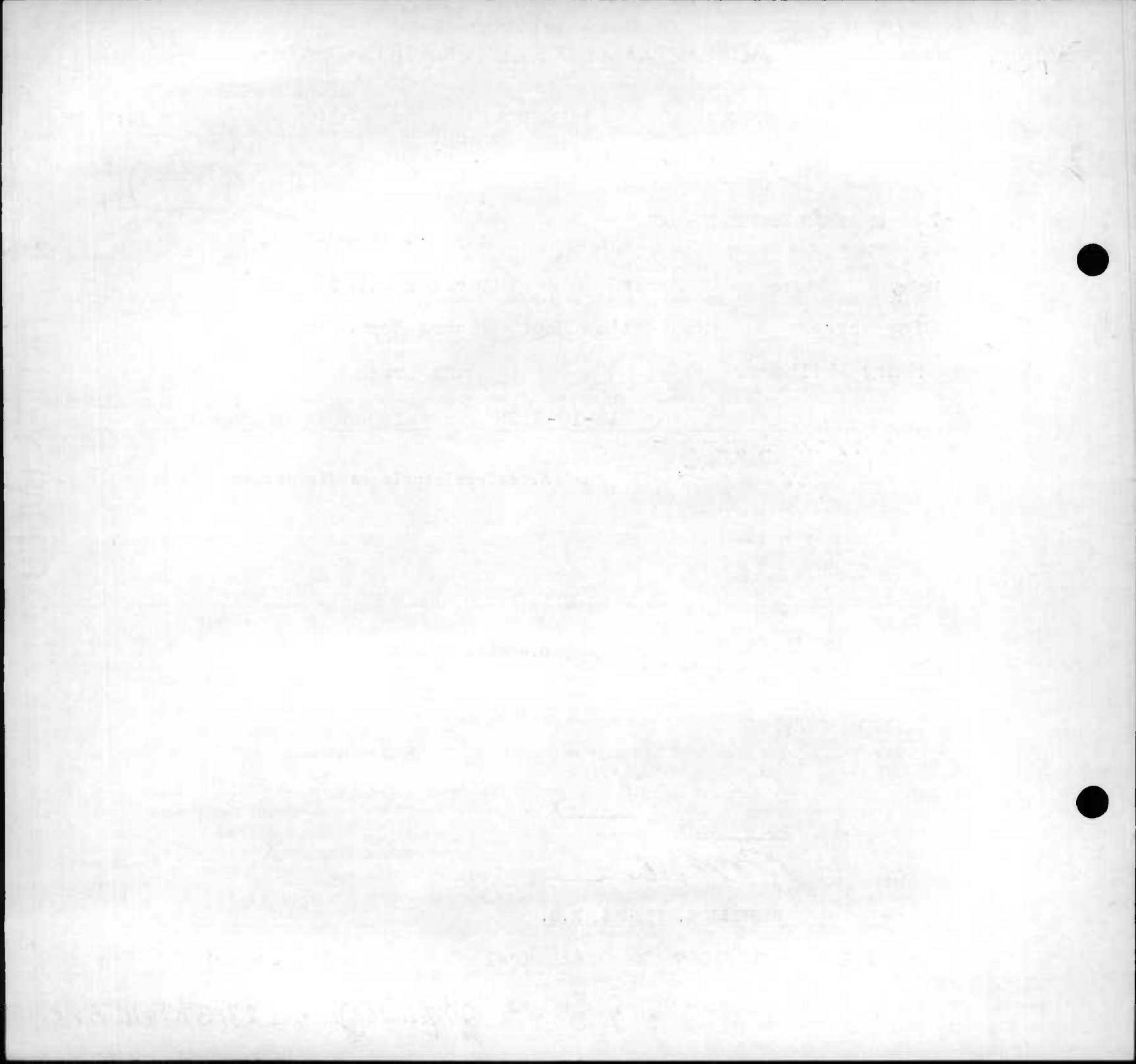
24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

J. Melville Jenkins 2713 Kirk Ave

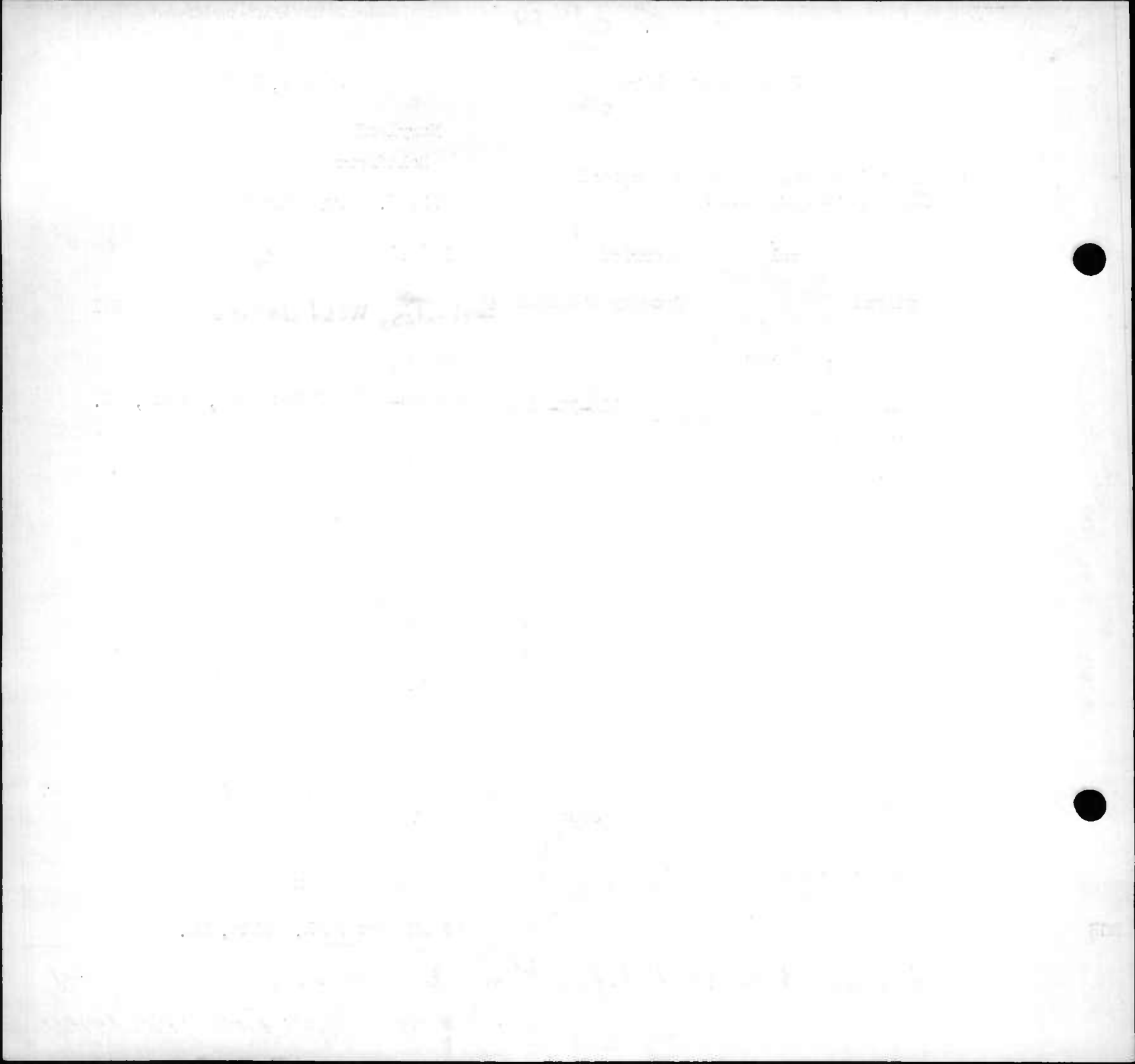
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5600				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5600	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) James Arthur Ford				2. DATE AND HOUR OF DEATH June 7, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION If not in hospital or institution, give street address or location US Public Health Service Hospital 3100 Wyman Park Drive				A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. STREET ADDRESS (If rural, give location) 529 N. Carey Street			
5. SEX M	6. RACE col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3/6/92	9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		
11. BIRTHPLACE (State or foreign country) Barbados, West Indies			12. CITIZEN OF WHAT COUNTRY? BWI			13. FATHER'S NAME Edward Ford	
14. MOTHER'S MAIDEN NAME Georgiana Ford			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 216-32-9109	
17. INFORMANT Records- US PHS Hospital, Balto, Md.			18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Congestive heart failure. Anteriosclerotic heart disease. Urinary tract infection (E. coli).			INTERVAL BETWEEN ONSET AND DEATH 2 days	
19. DATE OF OPERATION 0			20. AUTOPSY? (Yes or No) No			21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (I) (this hospital) attended the deceased from June 6, 1967 to June 7, 1967, that (I) (we) last saw the deceased alive on June 7, 1967 and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			23. SIGNATURE John W. White, M.D.			24. DATE SIGNED	
25. PHYSICIAN'S NAME (Type)			26. ADDRESS US PHS Hospital, Balto, Md.			27. DATE	
28. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park			29. LOCATION Arbutus			30. DATE	
31. DATE REC'D BY HEALTH DEPT. JUN 12 1967			32. NAME OF REGISTRAR Robert E. Johnson			33. FUNERAL DIRECTOR Morton A. Dyett F.H.	
34. ADDRESS 1701 Laurens			35. ADDRESS			36. ADDRESS	



67 5601

BALTIMORE CITY HEALTH DEPARTMENT

67 5601

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

LAWRENCE

WELDON

2. DATE AND HOUR PRONOUNCED DEAD

June 8, 1967

7:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1337 Gorsuch Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

9-1-1948

9. AGE (In years
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

School

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Lawrence Weldon

14. MOTHER'S MAIDEN NAME

Maxine McIntyre

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

N/A.

17. INFORMANT

ADDRESS

Maxine Hopkins 2954 Harford Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Massive Internal Bleeding
DUE TO stab wound of chest involving the
heart.

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

In front of 1808 E. 28th Street 9-06

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6/8/67 7:25 P.M.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

subject stabbed in chest

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

6/9/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/12/67

23C. NAME OF CEMETERY or CREMATORY

Baltimore NAT.

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 12 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

MORTON + Dyett

ADDRESS

1701 LAWRENS

Miss Mary P. - 1948

Student School
Frances Weldon
Marine McInTyre
W/A
Marine Hopkins 2124 Weldon

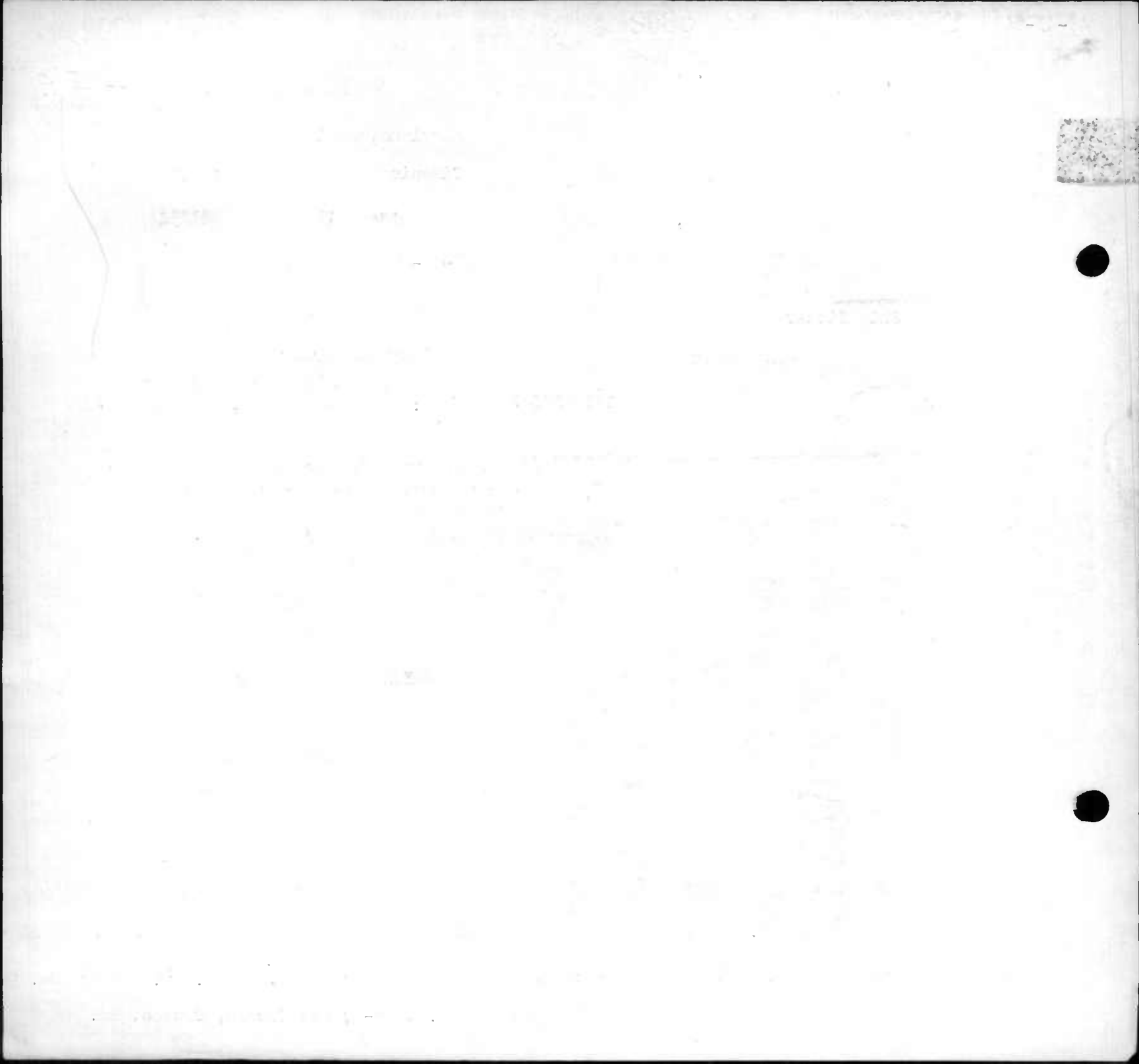
FORGET

Born 12/10/1901
Baptist Nat. B.A. 1914

BIRTH NO. 5-530		67 5602		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5602	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) GEORGE W. SMITH			
2. DATE AND HOUR OF DEATH 8 JUNE 1967 4:15 P.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTER N AVENUE BALTIMORE 21224, MARYLAND				A. STATE Maryland, Baltimore B. COUNTY Balts. Co.			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Timonium 21093				D. STREET ADDRESS (If rural, give location) 42 Cider Mill Road #21224			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-24-1889	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship fitter			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John Smith				
14. MOTHER'S MAIDEN NAME Mary Ann Greer			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 213 036547			17. INFORMANT BCH 4940 Eastern Avenue Baltimore, Maryland #21224				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) RECURRENT SQUAMOUS DUE TO AND BASAL CELL CARCINOMA FACE AND NECK.				INTERVAL BETWEEN ONSET AND DEATH ?			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7 JUNE 1967 to 8 JUNE 1967 , that (I) (we) last saw the deceased alive on 8 JUNE 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Daniel D. Foote				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8 JUNE 1967	
23C. PHYSICIAN'S NAME (Type) Daniel D. Foote				23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6, 10, 67		24C. NAME OF CEMETERY or CREMATORY Meadowridge		24D. LOCATION Md. Dorsey Rd. ##### Howard Co.	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1
E-450

67 5603		BALTIMORE CITY HEALTH DEPARTMENT		67 5603	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) CHARLES W. ELINE, 3rd.		2. DATE AND HOUR PRONOUNCED DEAD June 9, 1967 11:50 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL (DOA)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Owings Mills 53-00 D. STREET ADDRESS (If rural, give location) 34 Enchanted Hills Road Apt. #3			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH Feb. 20, 1967	9. AGE (In years last birthday) 3 1/2	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Wm. Eline, Jr.			
14. MOTHER'S MAIDEN NAME Barbara Leishuro		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Charles Wm. Eline, Jr. 34 Enchanted Hills Rd. - Apt. 3			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Interstitial Pneumonitis (SDII) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/9/67					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/10/67		23C. NAME OF CEMETERY or CREMATORY Meadowridge Cem.	
23D. LOCATION (City, town, or county) (State) Baltimore, Md.		24A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			
24B. NAME OF REGISTRAR Robert E. Taylor, M.D.		24C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.			

19670005612

Feb. 25, 1967

Seven United

State, Pa.

Barbara Leland

Charles W. Lane, Jr.

Charles W. Lane, Jr.
A. Nicholas Hill, Jr.

Investment

Barbara Leland

Investment

Investment

Investment

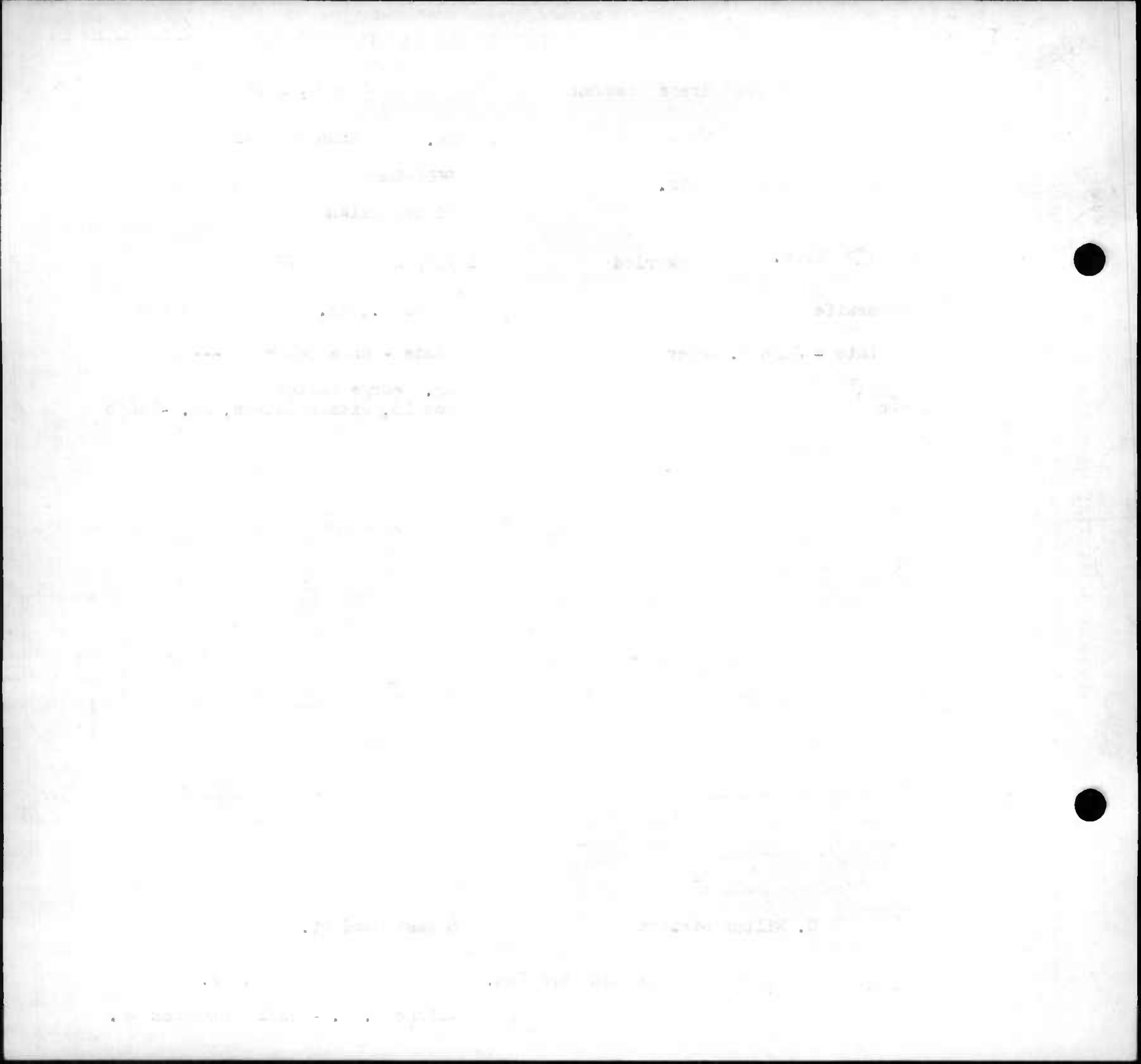
Barbara Leland

Investment

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

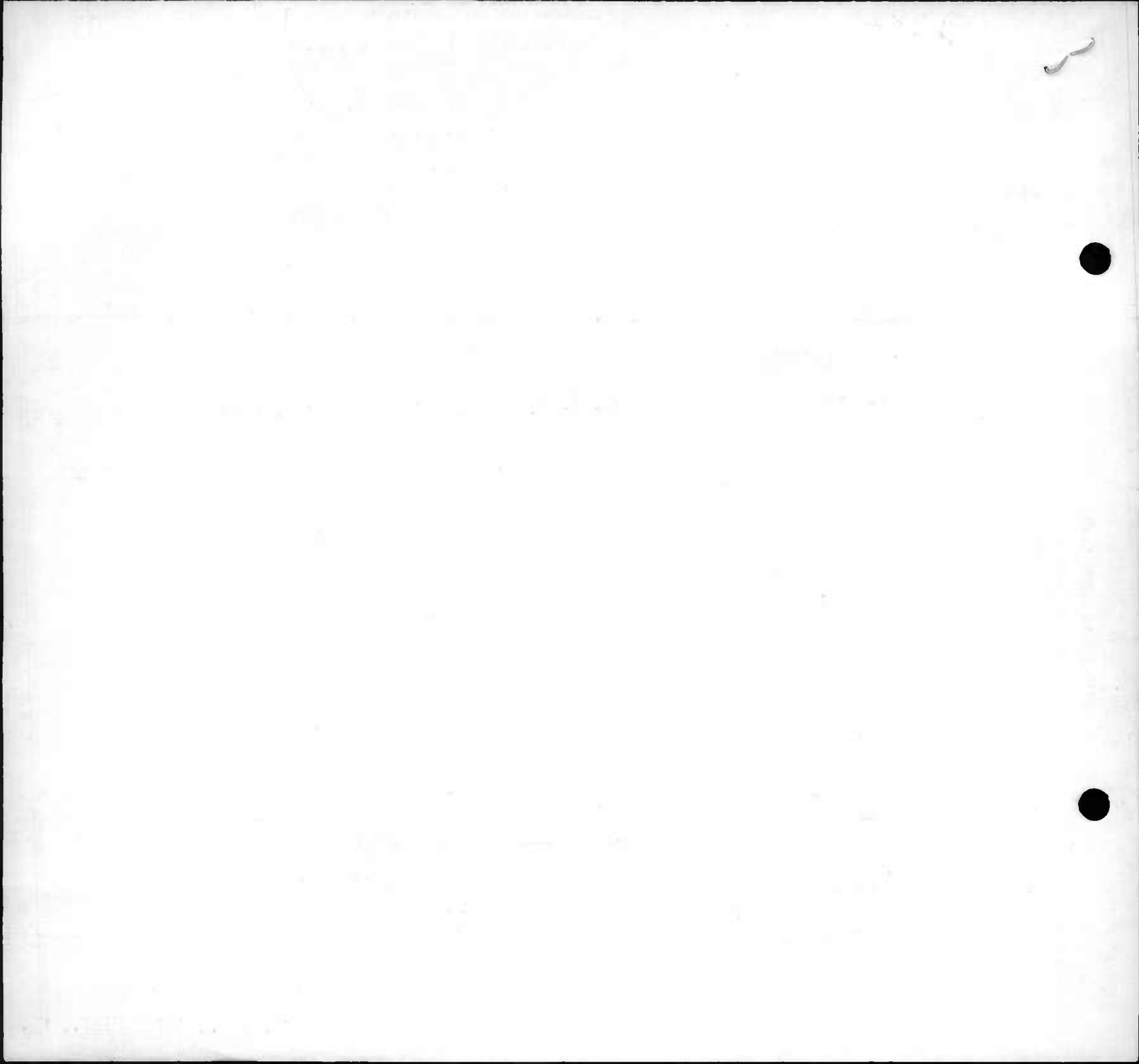
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5604	
CERTIFICATE OF DEATH					
BIRTH NO. 67 5604		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Blanche Irene Bawden			2. DATE AND HOUR OF DEATH June 9, 1967 5:50 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1110 Broadview Apts.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Anne Arundel Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) Gibson Island		
5. SEX F	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/19/94	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Late = John H. Lober		
14. MOTHER'S MAIDEN NAME Late - Rosa Belle ---			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Dr. George Bawden Box 26, Gibson Island, Md. -21056		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 5 minutes Old coronary infection Chronic myocarditis 2 years		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 11 19 66 to June 9th 19 67 , that (I) (we) last saw the deceased alive on June 9th 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. Wilbur Stewart				23B. DATE SIGNED 6/10/67	
23C. PHYSICIAN'S NAME (Type) C. Wilbur Stewart				23D. ADDRESS 6 East Read St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/67		24C. NAME OF CEMETERY or CREMATORY Louden Park Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			
25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Av.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 5605	
<div> <div>9432 67 5605</div> <div>BIRTH NO. 67 5605</div> </div>											
<div> <div>M.E. CASE NO.</div> <div>1. NAME OF DECEASED (Type or Print) MAURICE P. Goldstein</div> </div>											
<div> <div>2. DATE AND HOUR OF DEATH 6/8/67 12:13 P.M.</div> </div>											
<div> <div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</div> <div>SINAI HOSPITAL OF BALTIMORE</div> </div> </div>						<div> <div>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> <div> <div>A. STATE MARYLAND</div> <div>B. COUNTY 27-20</div> </div> </div>					
<div> <div>5. SEX M</div> <div>6. RACE W</div> <div>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED</div> </div>						<div> <div>8. DATE OF BIRTH 12/25/1899</div> <div>9. AGE (In years last birthday) 67</div> <div> <div>If Under 1 Yr. Months Days</div> <div>If Under 24 Hrs. Hours Min.</div> </div> </div>					
<div> <div>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN</div> <div>10B. KIND OF BUSINESS OR INDUSTRY AUTO.</div> </div>						<div> <div>11. BIRTHPLACE (State or foreign country) ELLICOTT CITY, MARYLAND</div> <div>12. CITIZEN OF WHAT COUNTRY? USA</div> </div>					
<div> <div>13. FATHER'S NAME ISAAC GOLDSTEIN</div> </div>						<div> <div>14. MOTHER'S MAIDEN NAME ETTA GEIS</div> </div>					
<div> <div>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</div> </div>						<div> <div>16. SOCIAL SECURITY NO. 213-01-9785A</div> <div>17. INFORMANT ADDRESS MRS. HILDA GOLDSTEIN, 7016 WALLIS AVENUE</div> </div>					
<div> <div>18. CAUSE OF DEATH</div> <div> <div>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)</div> <div> <div>(A) MYOCARDIAL INFARCTION</div> <div>(B) ASCVD</div> <div>(C)</div> </div> </div> </div>											
<div> <div>INTERVAL BETWEEN ONSET AND DEATH 13 days</div> </div>											
<div> <div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div> </div>											
<div>19A. DATE OF OPERATION</div>				<div>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>				<div>20A. AUTOPSY? (Yes or No) No</div>		<div>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div>	
<div>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</div>				<div>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div>				<div>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div>			
<div>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</div>				<div>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div>				<div>21F. HOW DID INJURY OCCUR?</div>			
<div> <div>22. I certify that (this hospital) attended the deceased from 5/24 1967 to 6/8 1967, that (I) last saw the deceased alive on 6/8/67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.</div> </div>											
<div>23A. SIGNATURE Abe Levy</div>						<div> <div>23B. DATE SIGNED 6/8/67</div> <div> <div>M.D. Attending Phys. <input type="checkbox"/></div> <div>Med. Director <input type="checkbox"/></div> <div>Staff Phys. <input checked="" type="checkbox"/></div> </div> </div>					
<div>23C. PHYSICIAN'S NAME (Type) ABE LEVY</div>						<div>23D. ADDRESS M.D. Sinai Hospital</div>					
<div>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</div>				<div>24B. DATE 6/9/67</div>				<div>24C. NAME OF CEMETERY OR CREMATORY BETH TELLOR</div>			
<div>24D. LOCATION BALTIMORE, MARYLAND</div>				<div>24E. LOCATION (City, town, or county) (State)</div>				<div>24F. LOCATION (City, town, or county) (State)</div>			
<div>25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967</div>				<div>25B. NAME OF REGISTRAR Robert E. Stalkor</div>				<div>25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., INC., 6010 REIST., RD.</div>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>67 5606</u>	
BIRTH NO. <u>5362</u>		M.E. CASE NO. <u>67 5606</u>		1. NAME OF DECEASED (Type or Print) <u>MELVILLE STRASBURGER</u>		2. DATE AND HOUR OF DEATH <u>6-7-67</u> <u>11:40 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>44 UNION MEMORIAL HOSP</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>12-01</u> D. STREET ADDRESS (If rural, give location) <u>BROADVIEW APARTMENTS, Apt. 327</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>12-9-79</u>	9. AGE (In years last birthday) <u>87</u>	10. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Advertising</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND, Westminster</u>	
13. FATHER'S NAME <u>VICTOR STRASBURGER</u>			14. MOTHER'S MAIDEN NAME <u>ROSALIE STERN</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>DAUGHTER, Mrs. Rosalee Josephson, Silver Spring, Md.</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>MYOCARDIAL INFARCTION</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ARTERIOSCLEROSIS</u> <u>INFLAMMATED WOUND</u>				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>5-29-67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>INGUINAL HERNIA</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5-29</u> 19 <u>67</u> to <u>6-7</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-7</u> 19 <u>67</u> and that in <u>(C)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(C)</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Edilberto Gozo, Jr.</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6-7-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>EDILBERTO GOZO, JR.</u>				23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/9/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Hebrew Friendship</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>			

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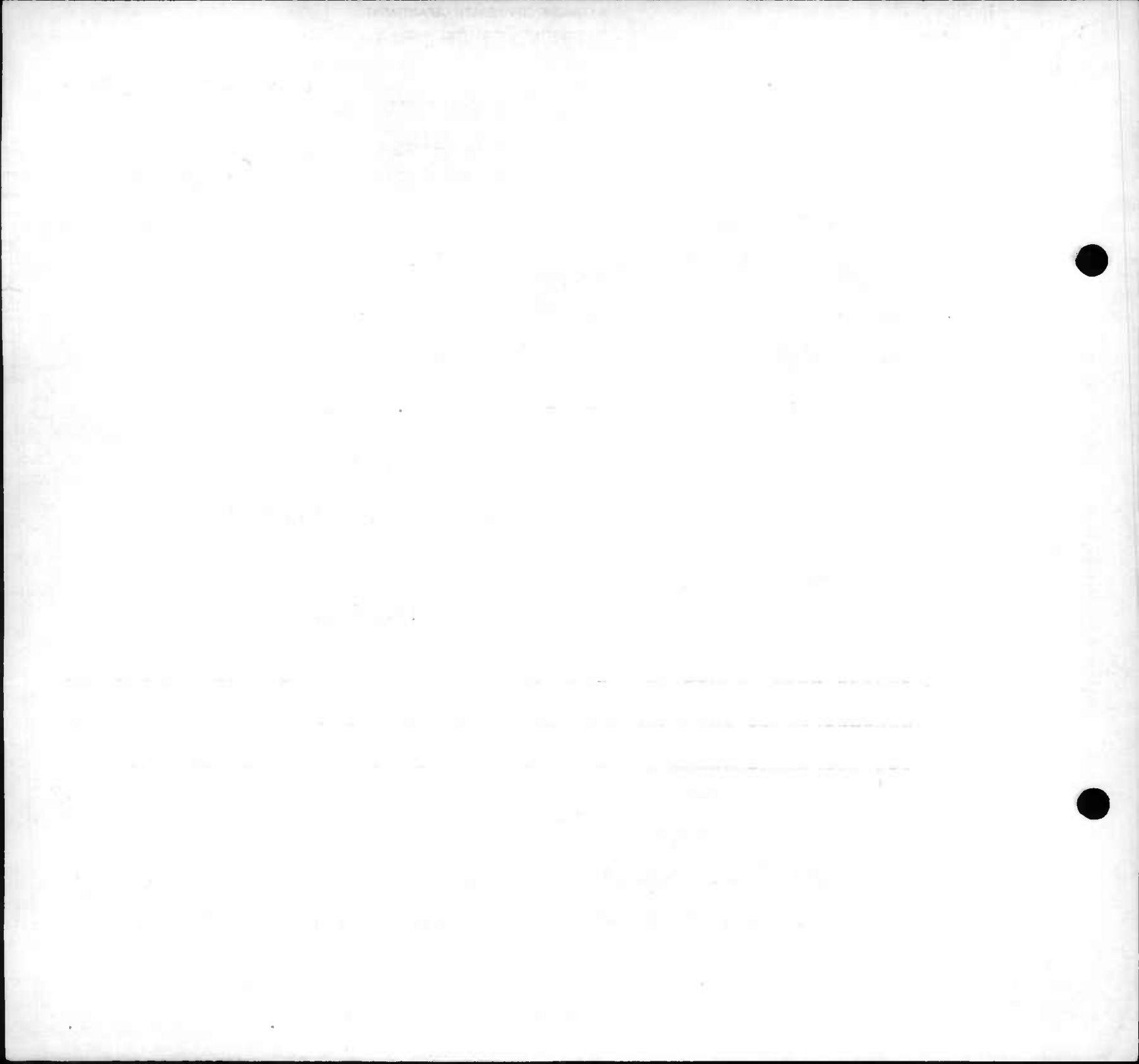
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5607	
BIRTH NO. 67 5607		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 6-8-67 1:00 P.M.			
1. NAME OF DECEASED (Type or Print) Martin James Quigley					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 00		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
3311 Rueckert Avenue		D. STREET ADDRESS (If rural, give location) 3311 Rueckert Avenue			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 11, 1898	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10B. KIND OF BUSINESS OR INDUSTRY Hospital Union Memorial		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Quigley			
14. MOTHER'S MAIDEN NAME Maria Roach		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I			
16. SOCIAL SECURITY NO. 215-24-1397		17. INFORMANT ADDRESS Edna P. Quigley 3311 Rueckert Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 + 260 X		CAUSE OF DEATH (A) Acute Myocardial Infarction (B) Arteriosclerotic Heart Disease (C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes Mellitus			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-12-65 to 5-27-67 and that (I) (we) last saw the deceased alive on 5-27-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sebastian Russo		M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/8/67	
23C. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO		23D. ADDRESS 5017 Harford Rd Baltimore 21214			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 12, 67		24C. NAME OF CEMETERY or CREMATORY Balto National Cem	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			
25B. NAME OF REGISTRAR Albert E. Talbot		25C. FUNERAL DIRECTOR ADDRESS Dippel Bros Inc. 7110 Belair Rd.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5608				CITY HEALTH DEPARTMENT				Registered No. 67 5608			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
				CHARLES CRAWFORD				6-10-67 8:35A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE				B. COUNTY			
35 CHURCH HOME AND HOSPITAL				MARYLAND							
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)							
				BALTIMORE				2-02			
				D. STREET ADDRESS (If rural, give location)							
				212 S. WOLFE ST							
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days					
M	W	WIDOWED	5-24-00	67							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
BOILER ENGINEER				CELENESE CORP.				BLOOMINGTON MARYLAND W. VA.			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
U.S.A				DAVE CRAWFORD				MARY M. ALBRIGHT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
YES WORLD WAR I				217-10-1285				EARL H. CRAWFORD ELKTON MD.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
5-27-71				PULMONARY EMPHYSEMA				YEARS			
19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				(A) DUE TO							
				(B) DUE TO							
				(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
0								NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-90 1967 to 6-10 1967, that (I) (we) last saw the deceased alive on 6-10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED			
Rodelio M. Lim								6-10-67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
Rodelio M. Lim				Church Home & Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY OR CREMATORY			
BURIAL				JUNE 13 67				SUNSET MEMORIAL PARK CEM			
								24D. LOCATION (City, town, or county) (State)			
								CUMBERLAND MD			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
JUN 12 1967				D. D. BROOKS				1800 E LOMBARD ST.			

RECEIVED

HARDMAN

BALTIMORE

315 N. W. 10th St.

2-24-62

MARYLAND

CHURCH MEMORIAL HOSPITAL

M. U. WIDENED

DAVE CRAWFORD

Planned Engineering

Robbie M. Linn
Robbie M. Linn

Blount House & Hospital

48-87-92

FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Anna June Julian

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)31 Baltimore City Hospital
4940 Eastern Ave. Baltimore, Md. 21224

5. SEX

Female

6. RACE

Cauc White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

6-9-21

9. AGE (In years
last birthday)

45

If Under 1 Yr.
Months; DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CLERK

10B. KIND OF BUSINESS OR INDUSTRY

AMERICAN DISTRIBUTING CO

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

George H SLATER

14. MOTHER'S MAIDEN NAME

Alice UNK

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

016-12-2545

17. INFORMANT

ADDRESS

RECORDS: BCM 4940 Eastern Avenue 21224

18. 100.7 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Pulmonary Metastases

(B) DUE TO

Carcinoma of Ethmoid
Sinus

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

3 months

1 year

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~the~~ (this hospital) attended the deceased from March 15, 1967 to June 8, 1967,
that ~~the~~ (we) last saw the deceased alive on June 8, 1967 and that in ~~my~~ (our) opinion death occurred on the date
and hour and from the causes stated above. (1) ~~We~~ (did) (did not) view the body after death.

23A. SIGNATURE

T. Herman Moore, Jr.

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

June 8, 1967

23C. PHYSICIAN'S
NAME (Type)

T. Herman Moore, Jr.

M.D.

23D. ADDRESS Baltimore City Hospitals
4940 Eastern Avenue Baltimore, Maryland 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

6/10/67

24C. NAME OF CEMETERY OR CREMATORY

LONDON PARK

24D. LOCATION

(City, town, or county)

(State)

FREDERICK AVE MD.

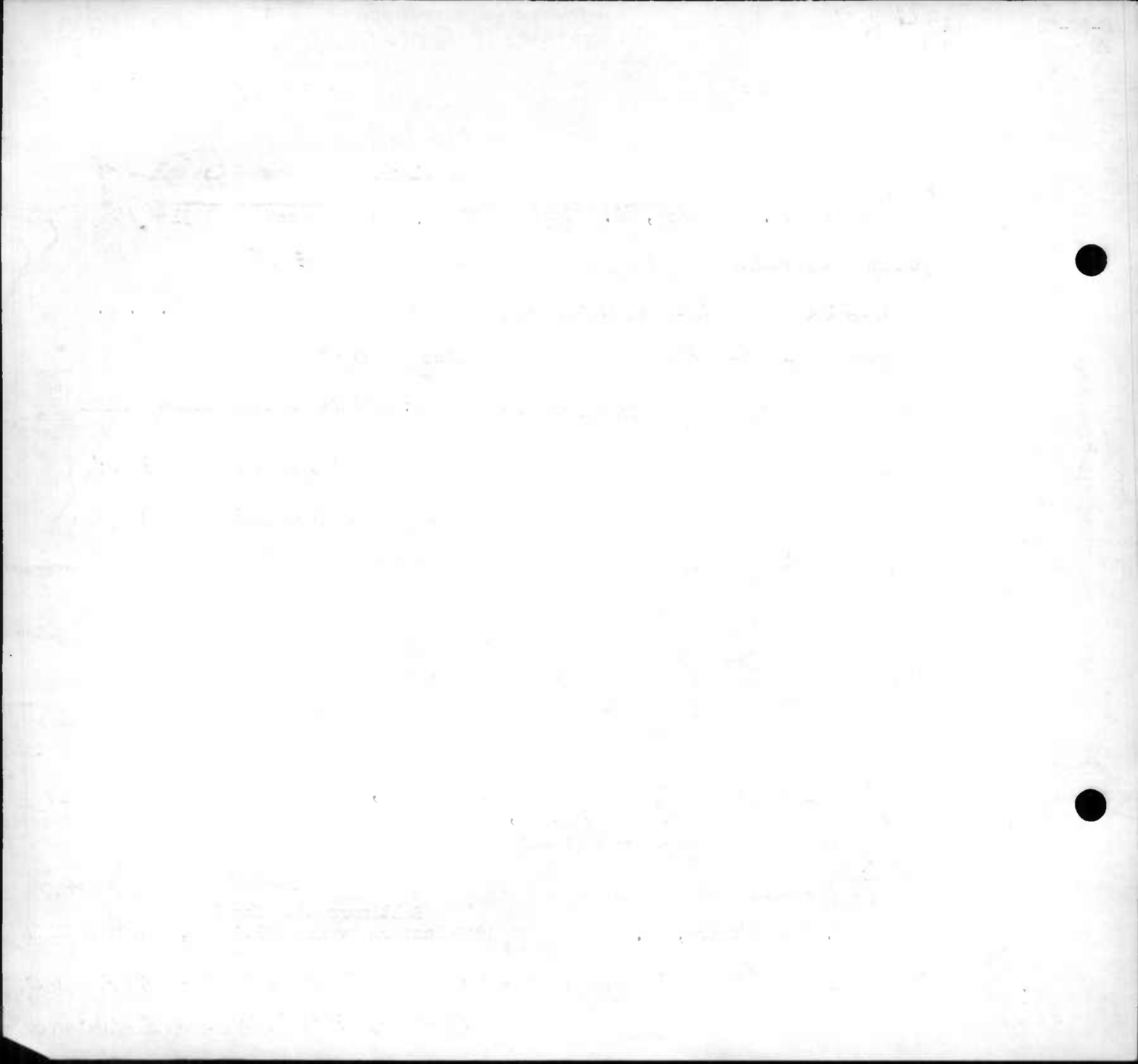
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

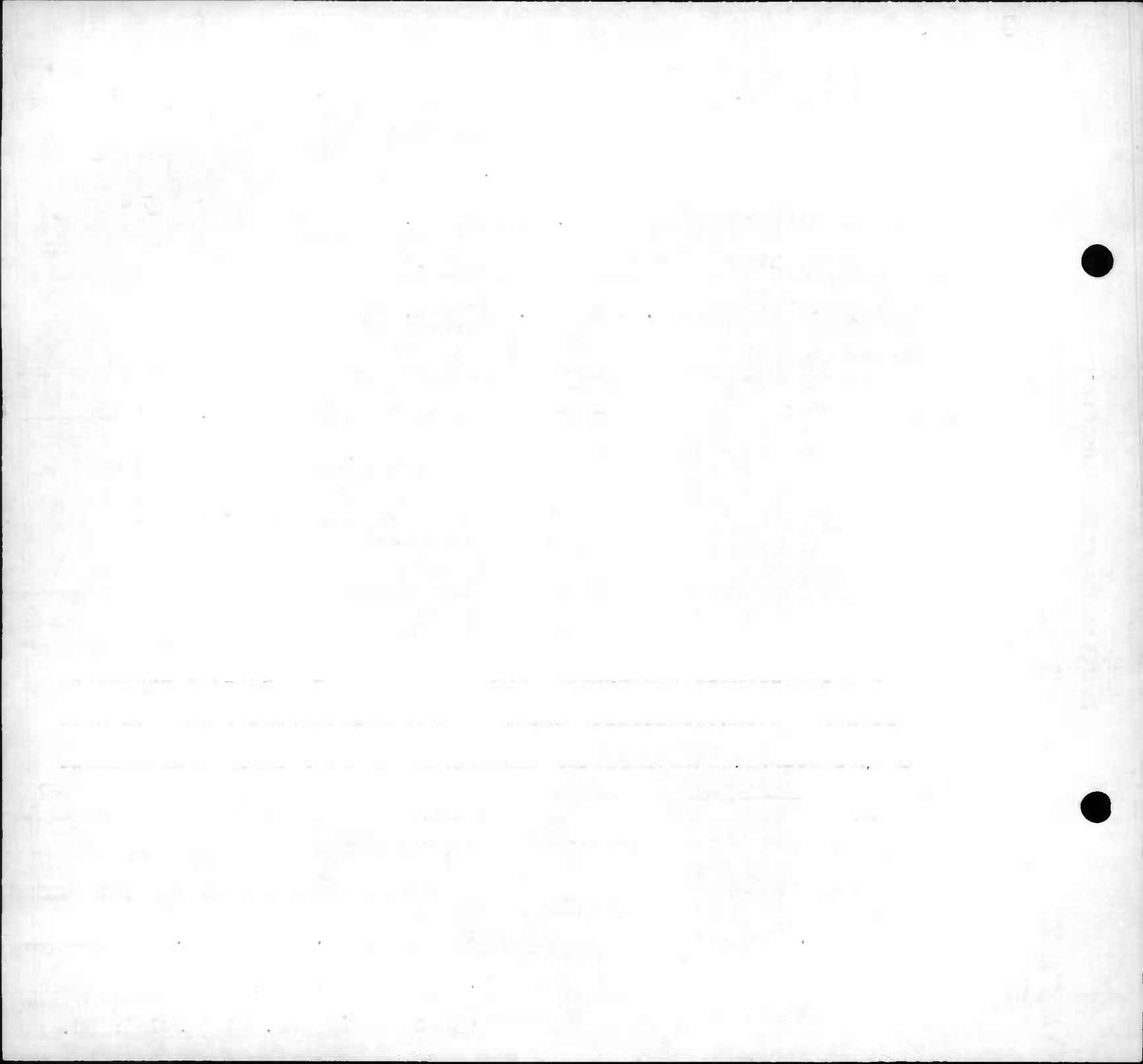
ADDRESS

DIPPEL BROS. INC. 1800 E. LOMBARD ST.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 5610		CERTIFICATE OF DEATH		67 5610	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Gregorio Lposich (or) Gregory F. Loposhich		June 8, 1967 12:05P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION		Maryland			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
90 Gould Convalesarium Belair Rd.		Baltimore		27-05	
		D. STREET ADDRESS (If rural, give location)			
		3420 E. Northern Pkwy			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.
Male	Caucasian	Married	Jan 25, 1887	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Bricklayer-retired		Beth. Steel Co.		Lischa, Russia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Feodor Loposhich		Ida Kozon		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes WW 1		213-09-4162		Irene Loposhich 3420 E. Northern Pk	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Myocardial Infarction DUE TO		8 days	
		(B) Atherosclerotic Cardiovascular DUE TO disease		30	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Paralysis Agitans			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 19 to 6/8 1967, that (I) (we) last saw the deceased alive on 6/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul B. Mueller				23B. DATE SIGNED June 9, 1967	
23C. PHYSICIAN'S NAME (Type) Paul G. Mueller				23D. ADDRESS 6411 Belair Rd. Balto Md. 21206	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		June 12		Holy Trinity Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 12 1967		Robert E. Talbot		Dippel Bros Inc. 7110 Belair Rd.	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 5611		67 5611		67 5611	
M.E. CASE NO.		Carroll			
1. NAME OF DECEASED (Type or Print)		Albert Kreitman			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH 6-9-67 1:45 P.M.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-44 D. STREET ADDRESS (If rural, give location) 5426 Hilltop Avenue # 6			
5. SEX MALE	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 5-22-93	9. AGE (In years last birthday) 74	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10B. KIND OF BUSINESS OR INDUSTRY Retired Koppers Co		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME Albert Kreitman			
14. MOTHER'S MAIDEN NAME Ada Emma White		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes US Navy WORLD WAR I			
16. SOCIAL SECURITY NO. 214 05 3131		17. INFORMANT Carolyn Giammona 5426 Hilltop Avenue			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Atherosclerosis (B) DUE TO Pyocardial Infarction (C) _____		INTERVAL BETWEEN ONSET AND DEATH years hours	
19A. DATE OF OPERATION 6/7/67 ; 6/8/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Right femoral artery obliteration		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from May 25 19 67 to June 9 19 67, that (2) (we) last saw the deceased alive on June 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alfred T. Cox		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/10/67	
23C. PHYSICIAN'S NAME (Type) Alfred T. Cox		23D. ADDRESS M.D. Church Home and Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 12 67		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) North Ave & Gay Streets		24E. LOCATION (City, town, or county) Md			
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Feltner		25C. FUNERAL DIRECTOR The Dippel Brothers Inc 1800 E Lombard St.	

years
hours

247

247

01/10/1947

1947

May 22

June 11

1947

Church Home and Hospital

Alfred T. Cox
Alfred T. Cox

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L-263

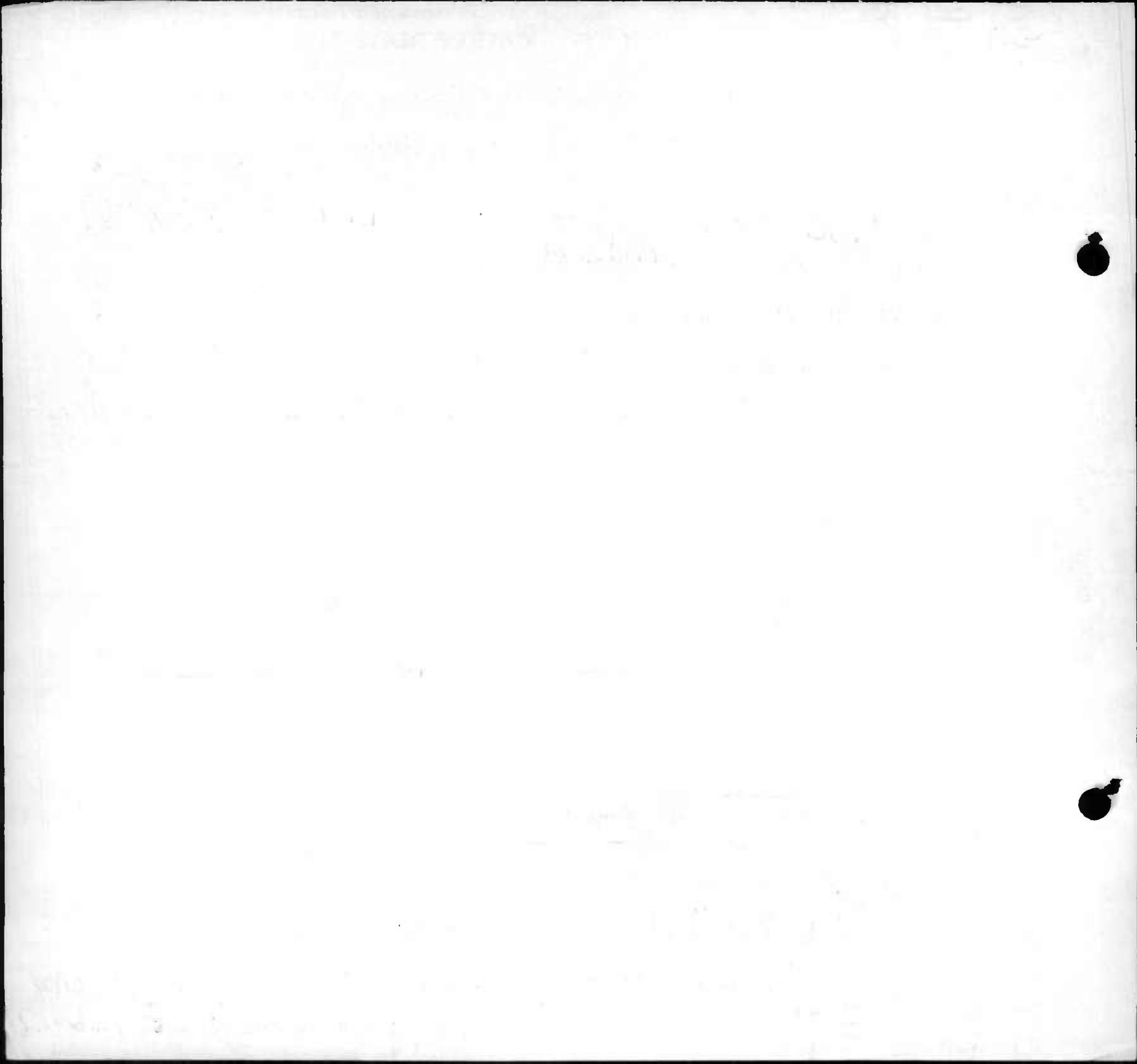
67 5612

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 5612

BIRTH NO.		DEATH NO.		Registered No.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE - B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location)		E. DATE OF BIRTH	
F. SEX		G. RACE		H. AGE (In years, last birthday)	
I. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		J. DATE OF BIRTH		K. AGE (In years, last birthday)	
L. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		M. KIND OF BUSINESS OR INDUSTRY		N. BIRTHPLACE (State or foreign country)	
O. FATHER'S NAME		P. MOTHER'S MAIDEN NAME		Q. CITIZEN OF WHAT COUNTRY?	
R. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		S. SOCIAL SECURITY NO.		T. INFORMANT ADDRESS	
U. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		V. CAUSE OF DEATH		W. INTERVAL BETWEEN ONSET AND DEATH	
X. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Y. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Z. MEDICAL CERTIFICATION	
AA. DATE OF OPERATION		AB. CONDITION FOR WHICH OPERATION WAS PERFORMED		AC. AUTOPSY? (Yes or No)	
AD. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		AE. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		AF. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
AG. TIME OF INJURY (Month) (Day) (Year) (Hour)		AH. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		AI. HOW DID INJURY OCCUR?	
AJ. I certify that (I) (the hospital) attended the deceased from May 13 1967 to June 9 1967, that (I) (we) last saw the deceased alive on June 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
AK. SIGNATURE L.C. Dobishall M.D.				AL. DATE SIGNED 6/9/67	
AM. PHYSICIAN'S NAME (Type) L.C. Dobishall				AN. ADDRESS 447 N. Kenwood Ave.	
AO. BURIAL CREMATION, REMOVAL (Specify)		AP. DATE		AQ. NAME OF CEMETERY or CREMATORY	
AR. DATE REC'D BY HEALTH DEPT.		AS. NAME OF REGISTRAR		AT. FUNERAL DIRECTOR ADDRESS	



1
m-300

BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5613			
BIRTH NO. 67 5613		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) JOHN MOODY		2. DATE AND HOUR PRONOUNCED DEAD June 8, 1967 9:50 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 33 49 JOHNS HOPKINS HOSPITAL (DOA)		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 7-04	
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL (DOA)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 1518 Ashland Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH Sep. 9, 1900
9. AGE (In years last birthday) 66		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Gloucester Co. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Walter Moody		14. MOTHER'S MAIDEN NAME Moriah Gales	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 21809-5514	
17. INFORMANT Louise Powell		ADDRESS 1518 ASHLAND ST.	
18. CAUSE OF DEATH I 199.2 Dissemminated Carcinomatosis DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. DATE SIGNED 6/8/67 EXAMINER'S NAME (Type)			
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 6/13/67	
23C. NAME of CEMETERY or CREMATORY MOUNT AUBURN CEM.		23D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
24A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		24B. NAME OF REGISTRAR Robert E. Fairley, M.D.	
24C. FUNERAL DIRECTOR I. L. Brown & Son		ADDRESS 123 W. Montgomery St	

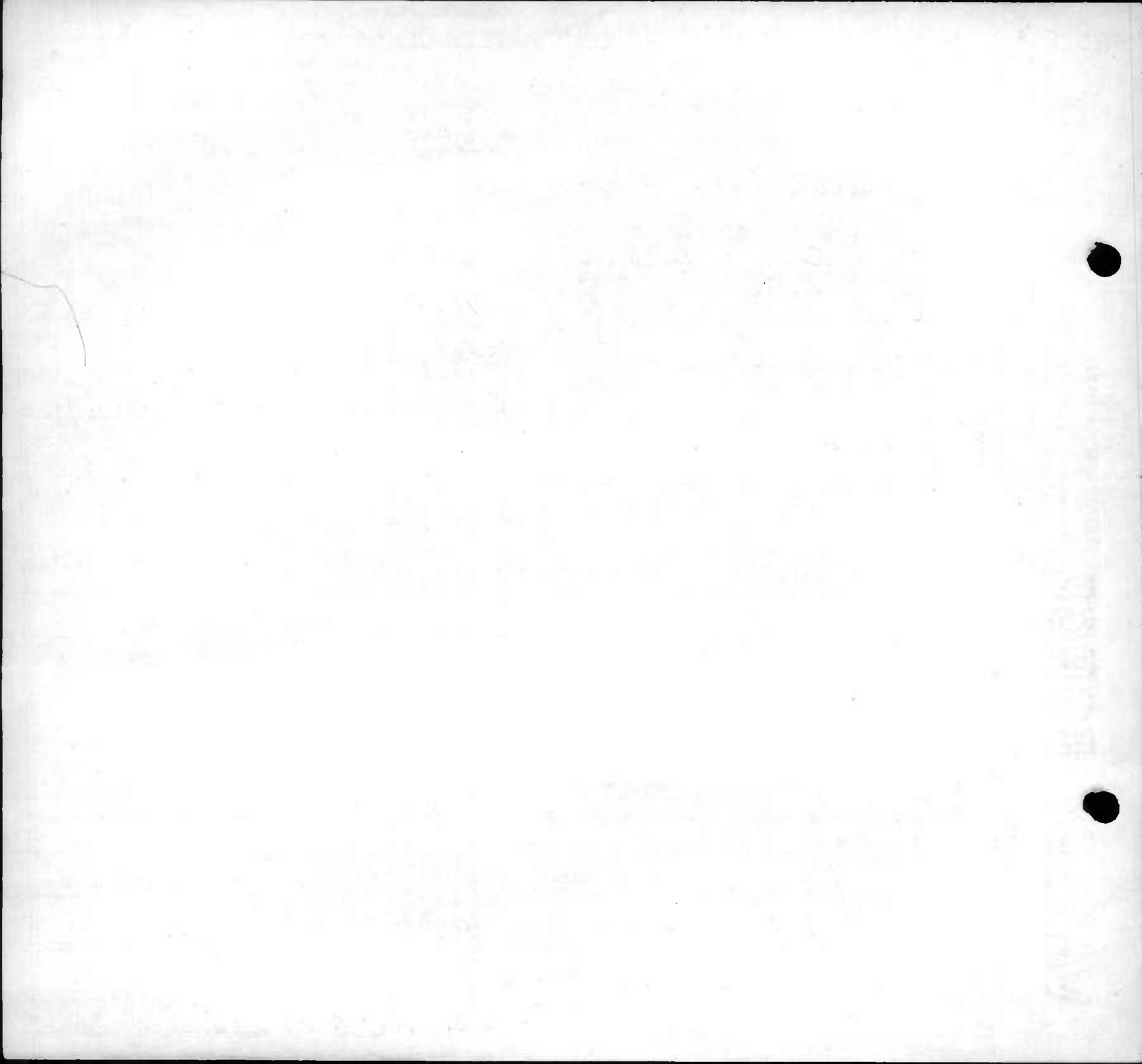
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REGISTERED U.S. PAT. & TM. OFF.
MADE IN U.S.A.

MADE IN U.S.A.

FUNERAL DIRECTOR: IMPORTANT

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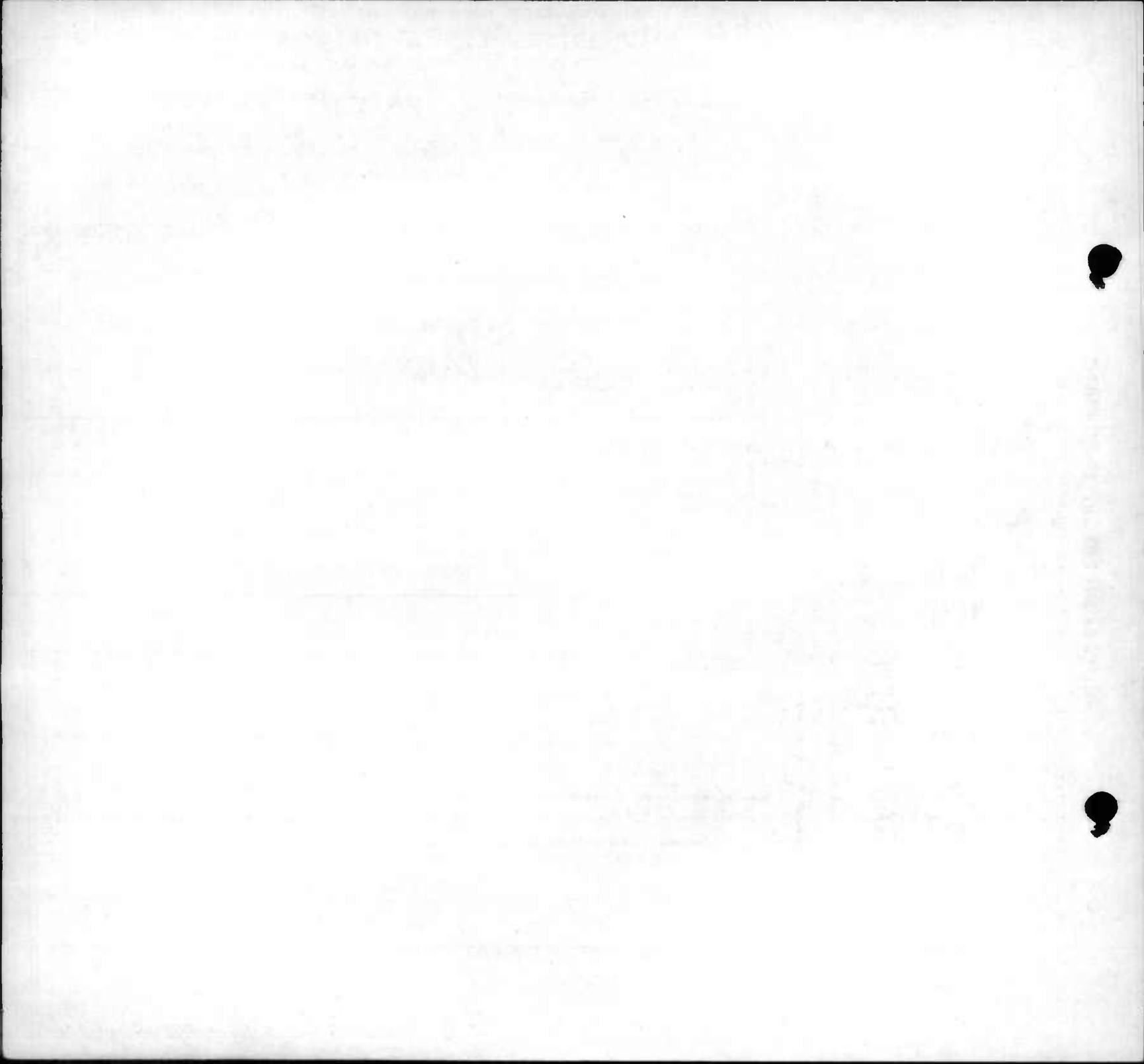
BALTIMORE CITY HEALTH DEPARTMENT				67 5614		67 5614	
BIRTH NO.				67 5614		67 5614	
M.E. CASE NO.				67 5614		67 5614	
1. NAME OF DECEASED (Type or Print)				HAIR, GEVENA		2. DATE AND HOUR OF DEATH 6-9-67 9:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 16-06		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 16	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hosp of Md. 46				D. STREET ADDRESS (If rural, give location) 2864 Harlem Ave.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-3-14	9. AGE (In years last birthday) 52	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Q	11. BIRTHPLACE (State or foreign country) N.C.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Spurgeon Johnson				14. MOTHER'S MAIDEN NAME Fannie Lee			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Jefferson Han 2864 Harlem Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 443 X 12260X (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Cerebro-vascular Accident 5 Hrs. + (B) Arteriosclerotic Hypertensive (C) Cardio-vascular Disease Unknown		INTERVAL BETWEEN ONSET AND DEATH 4 yrs ±	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 6-9 1967 to 6-9 1967, that (1) (we) last saw the deceased alive on 6-9 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R.J. Dureza				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-9-67	
23C. PHYSICIAN'S NAME (Type) R.J. Dureza				23D. ADDRESS M.D. 2413-A Cyburn Ave. Baltimore 15.			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal 6/13/67		24B. DATE 6/13/67		24C. NAME OF CEMETERY or CREMATORY Fayetteville		24D. LOCATION (City, town, or county) (State) N.C.	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Joseph E. Brown		25D. ADDRESS 108 Montgomery	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5615</u>	
BIRTH NO. <u>67-11542</u>		67 5615		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Baby Girl Hilton</u>		2. DATE AND HOUR OF DEATH <u>June 9, 1967 10:35 PM</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2301</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University of Md. Hospital</u>		D. STREET ADDRESS (If rural, give location) <u>1011 S. Hanover ST.</u>		5. SEX <u>Female</u> 6. RACE <u>Negro</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>—</u>		8. DATE OF BIRTH <u>6-9-67</u>		9. AGE (In years, last birthday) <u>9</u> Months <u>5</u> Days <u>0</u> Hours <u>50</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Herbert Hilton</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Johnson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Chart</u>	
18. <u>759.31</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Prematurity</u>		<u>9 hrs 9-50 min</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Multiple Cong. Anomalies</u>		"	
		(C) <u>? Chromosomal Error</u>		"	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>—</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>—</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-9</u> 19 <u>67</u> to <u>6-9</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-9</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Bernice Sigman</u> M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>June 9, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>Bernice Sigman</u> M.D.		23D. ADDRESS <u>University of Md Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried 6/12/67</u>		24B. DATE <u>6/12/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>108 W. Montgomery St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5616	
BIRTH NO. 67 5616		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 6/8/67 10:55 P.M.	
1. NAME OF DECEASED (Type or Print) EDWARD BURTON BRUTON		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND (?) B. COUNTY 13-03	
3. PLACE OF DEATH BALTIMORE, MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO (?)	
5. SEX M 6. RACE N 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) ?		D. STREET ADDRESS (If rural, give location) 1511 CLIFTON AVE (2501 SALEM ST.)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		11. BIRTHPLACE (State or foreign country) M.C. ?	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME EDWARD ? BRUTON		14. MOTHER'S MAIDEN NAME Jessie Williams	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 33562027		16. SOCIAL SECURITY NO.	
17. INFORMANT Dorothy Redmond		ADDRESS 1511 Clifton Ave	
18. 302 X1		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) PNEUMONIA RUL	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) D. T. 's	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) _____	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if) (this hospital) attended the deceased from 6/8 19 67 to 6/8 19 67 , that (we) (we) last saw the deceased alive on 6/8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Gary D. Plotnick		23B. DATE SIGNED 6/8/67	
23C. PHYSICIAN'S NAME (Type) Gary D. Plotnick		23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/12/67	
24C. NAME of CEMETERY or CREMATORY BALTO. NATIONAL		24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Fairman	
25C. FUNERAL DIRECTOR Joseph E. Lock		ADDRESS 1304 N. Central Ave	

6/16/67 - Form from funeral director. *JFC*

DATE RECEIVED

*Double William
Parker*

*Edward Graham
Parker*

*Double William
Parker*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>158886</u>
BIRTH NO. <u>67 5617</u>		CERTIFICATE OF DEATH		<u>67 5617</u>
M.E. CASE NO.		DATE AND HOUR OF DEATH <u>June 7th 1967 9²⁵ PM</u>		
1. NAME OF DECEASED (Type or Print) <u>Mrs Mary G. Cullison</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home and Hospital</u>		A. STATE <u>Pennsylvania</u> B. COUNTY <u>Gettysburg</u>		
If not in hospital or institution, give street address or location		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Gettysburg</u>		
		D. STREET ADDRESS (If rural, give location) <u>211 S. Washington St.</u>		
5. SEX <u>F.</u>	6. RACE <u>W.</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u>	8. DATE OF BIRTH <u>February 12th 1899</u>	9. AGE In years lost birthday <u>68 yr.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	12. CITIZEN OF WHAT COUNTRY? <u>American</u>
13. FATHER'S NAME <u>George Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Helen Eldred</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>176-07-9007</u>	17. INFORMANT <u>Mary G. Cullison</u>	
18. <u>002.11</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <u>Generalized pul. hbc severe</u>		
(This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.)		DUE TO		
ANTECEDENT CAUSES		(B)		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO		
		(C)		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Cardiac arrest</u>				
19A. DATE OF OPERATION <u>May 29th 1967</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pulm. hbc. bilateral</u>	20A. AUTOPSY? (Yes or No) <u>no</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>May 26th 1967</u> to <u>June 7th 1967</u> , that (we) last saw the deceased alive on <u>June 7th 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Merwin L. Trair, M.D.</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>June 7th 1967</u>
23C. PHYSICIAN'S NAME (Type) <u>MERWIN L. TRAIR</u>		23D. ADDRESS <u>Church Home and Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6/10/1967</u>	24C. NAME OF CEMETERY or CREMATORY <u>St. Francis Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Gettysburg, Adams Co., Pa.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1967</u>	25B. NAME OF REGISTRAR <u>Robert E. Bailey, M.D.</u>	25C. FUNERAL DIRECTOR <u>Robert G. Menden</u> ADDRESS <u>Gettysburg, Pa.</u>		

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5618

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

WILLIAM

D.

JOY

2. DATE AND HOUR PRONOUNCED DEAD

June 5, 1967

5:20 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

LUTHERAN HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4425 New Port Avenue

NEWPORT

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

May 2 1923

9. AGE (In years
last birthday)

44

10. If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Service Man

10B. KIND OF BUSINESS OR INDUSTRY

Oil Burners

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George W Joy

14. MOTHER'S MAIDEN NAME

IRA E Painter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

215 189992

17. INFORMANT

ADDRESS

Florence K Joy 4425 Newport Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

6/6/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

June 9-67

23C. NAME OF CEMETERY or CREMATORY

Dulzney Valley Mem.

23D. LOCATION

(City, town, or county)

(State)

Cockeysville Md

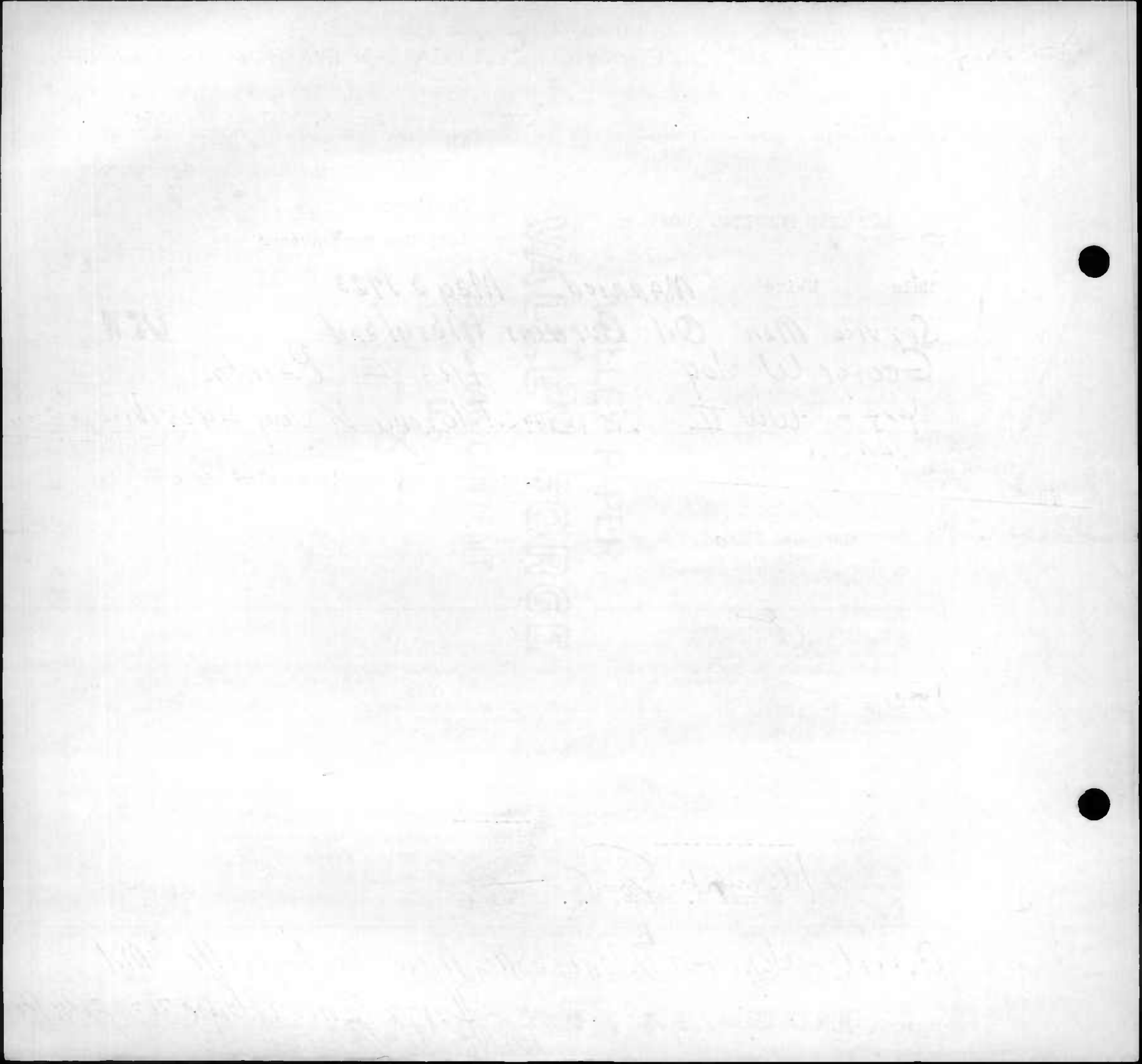
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

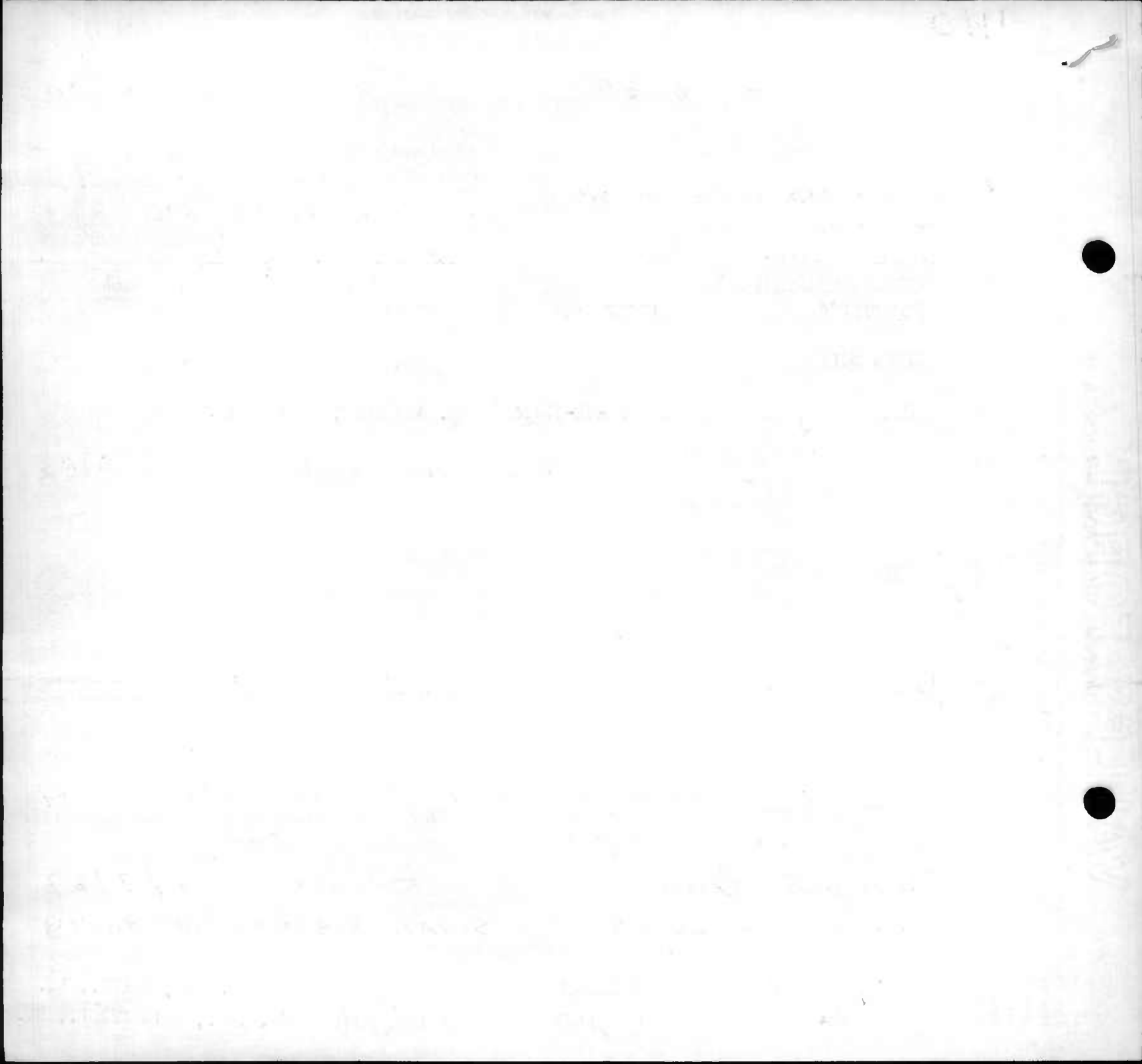
JUN 12 1967



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

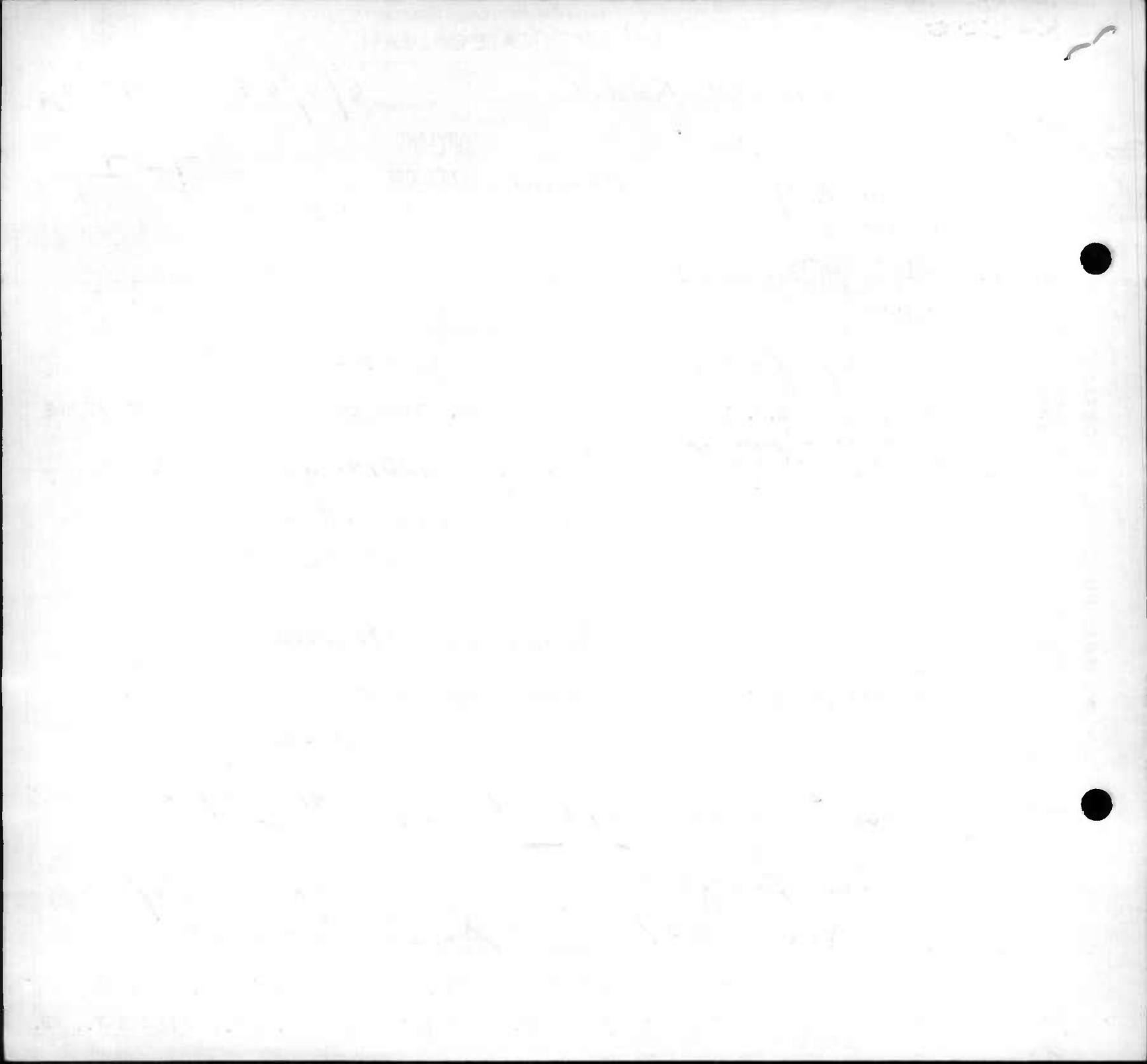
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5619	
BIRTH NO. 67 5619		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PAUL WOLF		2. DATE AND HOUR OF DEATH JUNE 7, 1967 8⁰⁵ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTO.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		27-15	
		D. STREET ADDRESS (If rural, give location) 6207 PIMLICO R.D			
5. SEX MALE	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1/28/94	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR		10B. KIND OF BUSINESS OR INDUSTRY DELICATESSAN		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME SIMON WOLF		14. MOTHER'S MAIDEN NAME SARAH ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 579-48-4742A		17. INFORMANT MRS. ANN WOLF, 6207 PIMLICO ROAD #9	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 465 XI PULMONARY EMBOLUS		CAUSE OF DEATH (A) DUE TO PULMONARY EMBOLUS (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 HOURS	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (This hospital) attended the deceased from 6/7 19 67 to 6/7 19 67 , that (I) (we) last saw the deceased alive on 6/7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Melvyn B. Lewis				23B. DATE SIGNED 6/7/67	
23C. PHYSICIAN'S NAME (Type) MELVYN B. LEWIS				23D. ADDRESS SINAI HOSPITAL OF BALTO.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/8/67		24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL	
24D. LOCATION (City, town, or county) (State) SOUTHERN AVENUE, BALTI., MD.		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			
25B. NAME OF REGISTRAR Robert E. Sullivan		25C. FUNERAL DIRECTOR SGL LEVINSON & BROS. INC., 6010 REIST., RD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

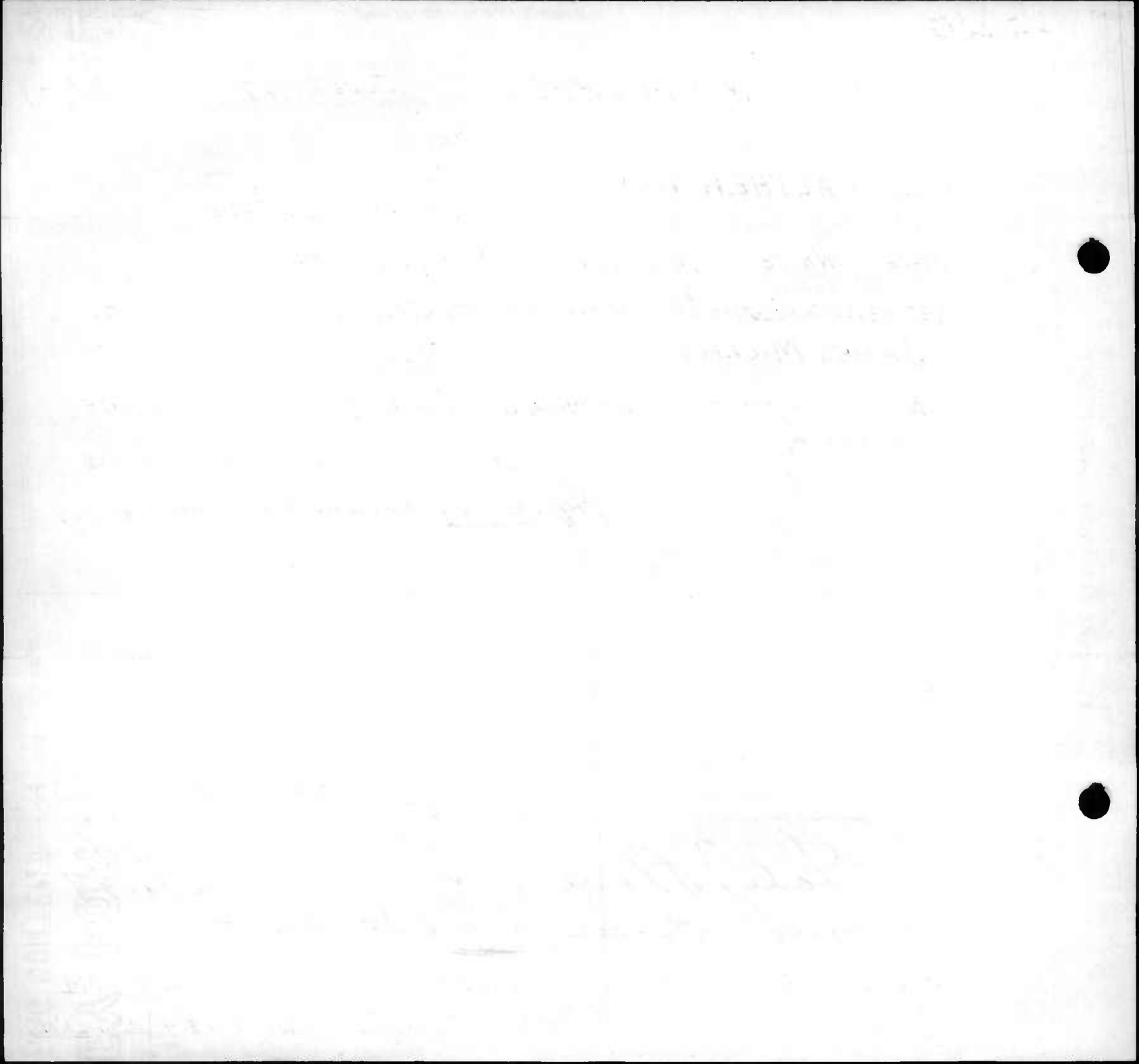
BIRTH NO. 67 5620				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5620	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) HYMAN KAHN			
2. DATE AND/HOUR OF DEATH 6/6/67 11:50 P.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 6402 PARK HEIGHTS AVENUE							
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH OCT. 27, 1891	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10B. KIND OF BUSINESS OR INDUSTRY PROPRIETOR		11. BIRTHPLACE (State or foreign country) LATVIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY KAHN				14. MOTHER'S MAIDEN NAME MINNA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. A 214-18-7765		17. INFORMANT MRS. MINNIE KAHN, 6402 PARK HEIGHTS AVENUE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 + 1 260X MYOCARDIAL INFARCTION				INTERVAL BETWEEN ONSET AND DEATH 8 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DIABETES MELLITUS							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/28 19 67 to 6/6 19 67 , that (I) (my) last saw the deceased alive on 6/6 19 67 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Abe Levy				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/6/67	
23C. PHYSICIAN'S NAME (Type) Abe Levy				23D. ADDRESS Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/8/67		24C. NAME OF CEMETERY or CREMATORY BETH YEHUDA ANSHE KURLAND		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Fickens		25C. FUNERAL DIRECTOR SQL LEVISON & BROS. INC., 6010 REIST., RD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 5621	
BIRTH NO. 67 5621		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ANTHONY M. MICHAEL			2. DATE AND HOUR OF DEATH JUNE 7, 1967 6:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4806 ALTHEA AVE.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 4806 ALTHEA AVE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JUNE 7 1891	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CLOTHING CUTTER CLOTHING FACTORY			11. BIRTHPLACE (State or foreign country) BALTO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES MICHAEL			14. MOTHER'S MAIDEN NAME MARY ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-09-5462	17. INFORMANT FAMILY		ADDRESS SAME
18. 443 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive Cerebrovascular Endarteriosclerosis 20 yrs			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6/6/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 55 to 6/7 19 67 . that (I) (we) last saw the deceased alive on 6/6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles J. Blazek M.D.				23B. DATE SIGNED 6/8/67	
23C. PHYSICIAN'S NAME (Type) CHARLES J. BLAZEK		23D. ADDRESS 1116 ST. PAUL ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-10-67		24C. NAME OF CEMETERY MOST HOLY REDEEMER	
24D. LOCATION (City, town, or county) (State) BELAIR RD. BALTO., MD		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			
25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR J. J. Blazek ADDRESS 5444 BELAIR RD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

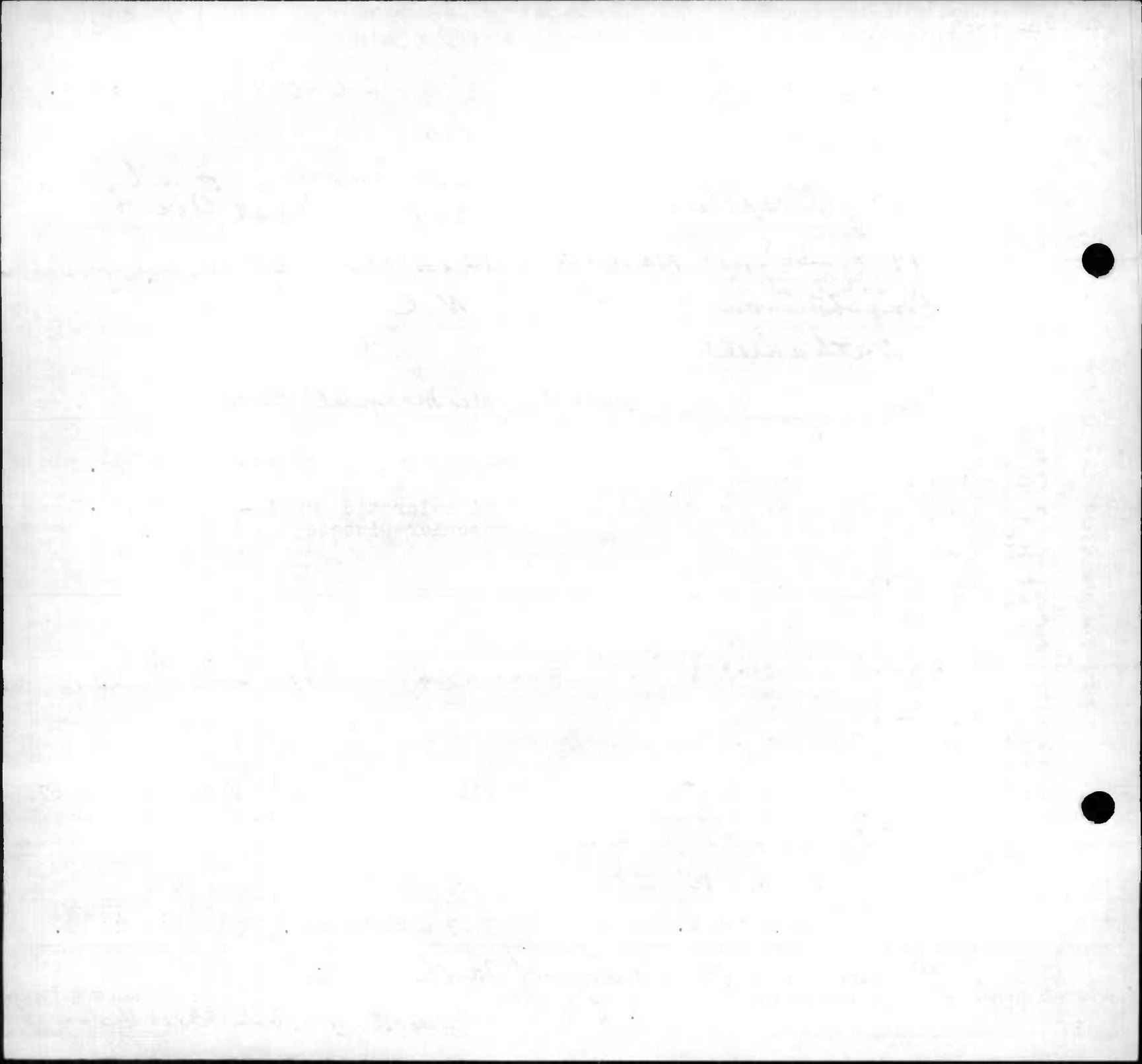
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5622</u>	
BIRTH NO. <u>67 5622</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JOSEPH WESLEY DOZSO</u>		2. DATE AND HOUR OF DEATH <u>June 8, 1967</u> <u>5:45</u> <u>A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00 109 S. Castle Street</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, with RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>109 S. Castle Street</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>4/17/96</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Meat Packing</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>WW I</u>			
16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT ADDRESS <u>213-03-9164 Mrs. Veronica Dozso, 109 S. Castle St.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>450.0 I</u> <u>Generalized arteriosclerosis</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/4</u> <u>1958</u> to <u>6/8</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>5/29/67</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>Irvin B. Kaplan</u>				23B. DATE SIGNED <u>6/9/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Irvin B. Kaplan</u>				23D. ADDRESS <u>129 S. Broadway, Balto Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/12/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Rosary</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. [illegible]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>M.F. SADOWSKI & SONS, 1808 EASTERN AVE</u>			

Continued on next page

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 5623		CERTIFICATE OF DEATH		67 5623	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Lerie H. Rice			6-6-67 7:45 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bk City Hospital			A. STATE Md. B. COUNTY		
5. SEX M			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
6. RACE W			D. STREET ADDRESS (If rural, give location) 809 S. East Ave.		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married			8. DATE OF BIRTH 12-17-1909		
9. AGE (In years lost birthday) 57			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Long Shoreman		
11. BIRTHPLACE (State or foreign country) N.C.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Nathaniel			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-059212		
17. INFORMANT Mrs. Margaret Rice			ADDRESS Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Artery Disease			INTERVAL BETWEEN ONSET AND DEATH 4 yrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Arteriosclerotic Cardio-vascular Disease 5 yrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from April 19 49 to June 19 67, that (I) (we) last saw the deceased alive on May 1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Clarence W. LeDoux			23B. DATE SIGNED 6/9/67		
23C. PHYSICIAN'S NAME (Type) Clarence W. LeDoux			23D. ADDRESS 3023 Eastern Ave. Baltimore 24 Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-10-67		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION Md.		24E. NAME OF REGISTRAR Robert E. Johnson		24F. FUNERAL DIRECTOR Alfred E. Hoffmann	
24G. DATE RECEIVED BY HEALTH DEPT. JUN 12 1967		24H. NAME OF REGISTRAR Robert E. Johnson		24I. ADDRESS 3218 Hudson St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5624	
BIRTH NO. 67 5624		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mary E. FOX		2. DATE AND HOUR OF DEATH June 7th 1967 3:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-38	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Md.		D. STREET ADDRESS (If rural, give location) 3410 Gwynns Falls PKWY			
5. SEX F.	6. RACE C.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3/3/04	9. AGE (In years last birthday) 63	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rocky Mount, N. C.	
13. FATHER'S NAME William Tucker		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Daughter, Ruth Boddie	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fracture of Rt. Femur Chronic Brain Syndrome Constrictive Heart Failure		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		MEDICAL EXAMINER (A) W. D. Kim DEPUTY OR ASST. MEDICAL EXAMINER (B) W. D. Kim C. W. D. Kim			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture (Rt) Femur					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore City 15-38	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell down	
22. I certify that (I) (this hospital) attended the deceased from May 1st 1967 to June 7th 1967 . that (I) (we) last saw the deceased alive on June 7th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. D. Kim				23B. DATE SIGNED June 7th 1967	
23C. PHYSICIAN'S NAME (Type) W. D. Kim		23D. ADDRESS Lutheran Hospital of Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-11-67		24C. NAME OF CEMETERY or CREMATORY Social Union	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR Charles R. Law	
				ADDRESS 802 Madison Ave.	

Chief E. H. Beck

Chaplain

C. H. Jones

Imperial Hospital of Md. 3400 Avenue Hills Park

W. G. Jones

1944

Imperial, Auto Accident

Insurance of Mt. Vernon

Imperial Hotel, Inc.

to

Imperial

Imperial Hotel, Inc.

Imperial Hotel, Inc.

Imperial Hotel, Inc.

Imperial Hotel, Inc.

Imperial Hotel, Inc.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5625	
BIRTH NO. 64-21368 67 5625					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Joseph Thomas Dawson			2. DATE AND HOUR OF DEATH 6/9/67 9:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital Balto., Md. 21201			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 549 E. Fort Ave		
5. SEX m	6. RACE w	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 8/10/64	9. AGE (In years last birth) 2 1/2	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME George T. Dawson			14. MOTHER'S MAIDEN NAME Dawn L. Gregory		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Hosp. chart.		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 754.10 Thrombembolism of brain Antecedent causes Diseases or conditions, if any, giving rise to the above cause (A) stating the underlying condition last.			CAUSE OF DEATH (A) Thrombembolism of brain (B) Tuberology of fallopian (C)		INTERVAL BETWEEN ONSET AND DEATH 6 days life
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) no	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 7, 1967 to June 9, 1967, that (I) (we) last saw the deceased alive on June 9, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Franklin L. Johnson				23B. DATE SIGNED June 9/67	
23C. PHYSICIAN'S NAME (Type) Franklin L. Johnson				23D. ADDRESS University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/67		24C. NAME OF CEMETERY or CREMATORY Holy Cross	
24D. LOCATION (City, town, or county) (State) A.A. County, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR McCully Funeral Home Balto Md.			

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George T. Dawson

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Balto

244 E Fort Ave

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Dawn George

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University Hospital
Baltimore, Md 21501

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George T. Dawson

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10/10/12

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University Hospital

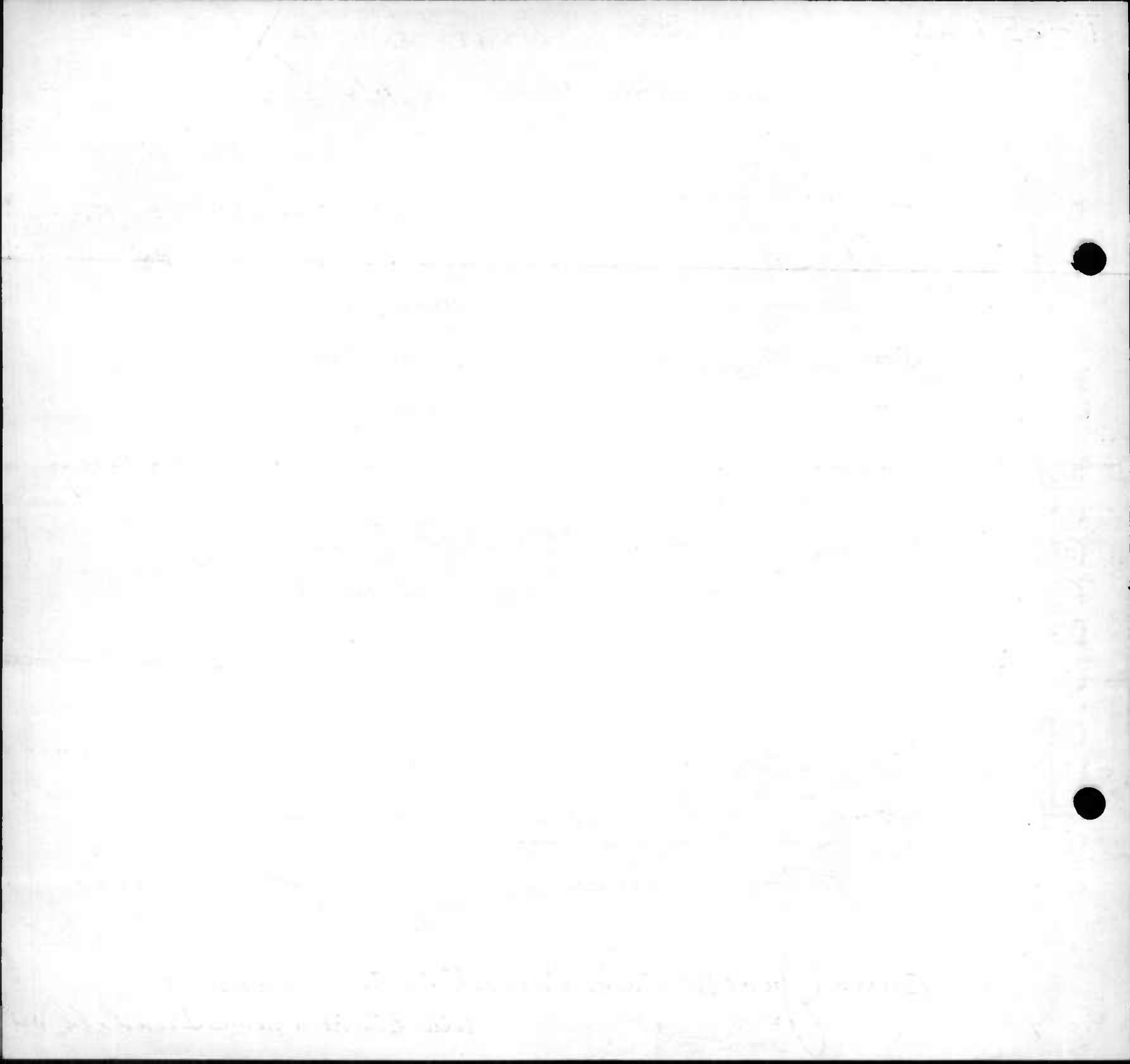
George T. Dawson

10/10/12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 5626					Registered No. 67 5626					
BIRTH NO. 67-10694					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>TURNBULL BABY BOY</u>					2. DATE AND HOUR OF DEATH <u>6/6/67 10:55 P.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balt. Co.</u>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 SINAI HOSP OF BALTIMORE</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 53-00</u>					
D. STREET ADDRESS (If rural, give location) <u>420 CARROLLWOOD RD</u>										
5. SEX <u>m</u>	6. RACE <u>w</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>never</u>	8. DATE OF BIRTH <u>6/5/67</u>	9. AGE (In years last birthday) <u>0</u>	If Under 1 Yr. Months: <u>12</u> Days: <u>12</u> Hours: <u>12</u> Min.		10. UNDER 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>DAVID TURNBULL</u>					14. MOTHER'S MAIDEN NAME <u>Constance</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Chart</u>			ADDRESS		
18. <u>773.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Distress</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Immaturity</u>					CAUSE OF DEATH (A) <u>Respiratory Distress</u> (B) <u>Immaturity</u> (C) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 Days</u> <u>1 1/2 Days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (at) (this hospital) attended the deceased from <u>6/5</u> 19 <u>67</u> to <u>6/6</u> 19 <u>67</u> , that (at) (we) last saw the deceased alive on <u>6/6</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Barbara C. Wagner</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <u>6/6/67</u>					
23C. PHYSICIAN'S NAME (Type) <u>—</u>					23D. ADDRESS M.D. <u>SINAI HOSP OF BALTIMORE</u>					
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>June 8/67</u>		<u>Oak Lawn Cemetery</u>			<u>Balt Co</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1967</u>		25B. NAME OF REGISTRAR <u>R. E. F. F. F.</u>			25C. FUNERAL DIRECTOR <u>W. H. F. F.</u>			ADDRESS <u>W. H. F. F.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. X
67 5627		67 5627		
BIRTH NO.		M.E. CASE NO.		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
VIRGIL MILLER		6/7/67 6:25 AM.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL 100 N. BROADWAY BALTIMORE, 31, MD		A. STATE Md. B. COUNTY Baltimore Co.		
5. SEX M W		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH
WELDER		AUTO BODY MFR.		5/13/12
11. BIRTHPLACE (State or foreign country)		9. AGE (In years last birthday)		12. CITIZEN OF WHAT COUNTRY?
W. VA.		55		USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
JOHN MILLER		MAE WALLS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
Yes WWII				21222 Mrs. LOUIE MILLER, 2106 BAYBRIAR RD.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
527.11		CHRONIC OBSTRUCTIVE		
ANTECEDENT CAUSES		(A) PULMONARY EMPHYSEMA		yes
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) HYPERTENSIVE CARDIOVASCULAR DISEASE & CHRONIC CONGESTIVE HEART FAILURE		yes
II		(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
D				NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (if at this hospital) attended the deceased from 6/4 1967 to 6/7 1967, that (I) (we) last saw the deceased alive on 6/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
Francisco Baltazar, M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				6/7/67
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
FRANCISCO BALTAZAR, M.D.		CHURCH HOME & HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
BURIAL				HOLLY HILL MEN. GARDENS BALTO. CO., MD.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
JUN 12 1967		R. E. S. Feltner		VOZIRISH FUNERAL HOME, DUNDALK, MD.

THE HEART PATIENT
LIFE & DEATH
HYPERTENSIVE CARDIOMYOPATHY
LIFE & DEATH
LIFE & DEATH

FRANCIS PATTERSON
LIFE & DEATH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5628					Registered No. 67 5628				
CERTIFICATE OF DEATH									
BIRTH NO.		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH	
					George Leonard Doenges			6-10-67 2 ⁴⁰ P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
49 NORTH Charles General Hospital					Baltimore - Maryland.				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					BALTIMORE				
					D. STREET ADDRESS (If rural, give location)				
					5565 Cedonia Av. 21206				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
M	W	MARRIED		6-26-18	48	-		-	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Machine operator			Wester Electric		BALTIMORE Md.		U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
George L Doenges					Anna Lang				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
WW-2					MARY (Wife)			5565 Cedonia Av 21206	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					Carcinoma of the pancreas				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					5-7-67				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(B) DUE TO				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(C) DUE TO				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					5-7-67				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
16-5-67									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 5-7-67 to 6-10-67, that (I) (we) last saw the deceased alive on 6-10-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 2 ⁴⁰ pm.									
23A. SIGNATURE					23B. DATE SIGNED				
Luis E. Rengel									
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Pedro De Borja					1020 ARMISTEAD Way - 21205				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		6/14/67		Holy Redeemer Crm.		Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUN 12 1967		Luis E. Rengel		Pedro De Borja		2818 E. Balto. St.			

George ... 8-10-61

Baltimore - Maryland

North ...
2222 ...

Machine operator ...
George & ...

Mary (Wife) ...
Certificate of the ...

8-7-61

8-10-61 ...

John De ...
... 8-10-61

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5629		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5629	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HOWARD K. McCOMAS Jr.		6/9/67 2:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
33 THE JOHNS HOPKINS HOSPITAL			MARYLAND HARFORD		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
ABINGDON 21009 62-00			ABINGDON ROAD		
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
MALE		WHITE		MARRIED	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
6-2-04		63		Mortician	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Harford Co., Maryland		U. S.		HOWARD K. McCOMAS Sr.	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
ANNA RIEGER		No		219-22-5555	
17. INFORMANT		18. 465X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. CAUSE OF DEATH	
Mrs. Howard K. McComas		(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Cerebrovascular accident	
ADDRESS Same		ANTECEDENT CAUSES		(B) polycythemia	
		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) chronic pulm emboli	
20. INTERVAL BETWEEN ONSET AND DEATH		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		22. II pneumonia and phlebitis	
23. MEDICAL CERTIFICATION		24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0		26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
28. TIME OF INJURY (APPROX.)		29. INJURY OCCURRED		30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		31. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6/9/67 to 6/9/67, that (1) (we) last saw the deceased alive on 6/9/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.		32. SIGNATURE		33. DATE SIGNED	
PETER J. ROSEN		M.D.		6/9/67	
34. PHYSICIAN'S NAME (Type)		35. ADDRESS		36. DATE	
PETER J. ROSEN		THE JOHNS HOPKINS HOSPITAL		6/9/67	
37. BURIAL CREMATION, REMOVAL (Specify)		38. DATE		39. NAME OF CEMETERY or CREMATORY	
Burial		June 11, 1967		Cokesbury Memorial Cem.	
40. LOCATION (City, town, or county) (State)		41. DATE REC'D BY HEALTH DEPT.		42. NAME OF REGISTRAR	
Abingdon, Harford Co., Md.		JUN 12 1967		George J. Gonce	
43. FUNERAL DIRECTOR		44. ADDRESS		45. DATE	
George J. Gonce		4001 Ritchie Hwy. Balto. Md. 21225		6/9/67	

1. The first of the following is a

very good example of the
work of the same hand.

2. The second is a very good

example of the work of the same hand.
The third is a very good example of the work of the same hand.
The fourth is a very good example of the work of the same hand.
The fifth is a very good example of the work of the same hand.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
1. NAME OF DECEASED (Type or Print)		ZIEGLER, M. JEANNETTE		2. DATE AND HOUR OF DEATH JUNE 8, 1967 5:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		MARYLAND 2027	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MD. 21229		D. STREET ADDRESS (If rural, give location)		1211 LINDEN AVENUE	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 4-30-87	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		NONE		PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME JOHN BERGE		14. MOTHER'S MAIDEN NAME CHARLOTTE (HENSSEN) BERGE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219 54 3320		17. INFORMANT ADDRESS HOSPITAL RECORDS-ST. AGNES HOSPITAL	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION CAUSING DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) LEFT MIDDLE CEREBRAL THROMBOSIS DUE TO (B) PANCREATITIS DUE TO (C) RUPTURED STOMACH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 7, 1967 to JUNE 8, 1967, that (X) (we) last saw the deceased alive on JUNE 8, 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE FEDERICO POLLICINA		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-9-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS CATON AND WILKENS AVE. BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-10-1967		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR R. E. F. F. F.	
25C. FUNERAL DIRECTOR H. H. H. H. H.		25D. ADDRESS 307 W. North Ave			

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FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 5631				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5631	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
JOZWIAK, SR				JOSEPH FRANK		2. DATE AND HOUR OF DEATH	
JUNE 8, 1967				12-58P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
40 ST. AGNES HOSPITAL				MARYLAND Anne Arundel Co			
5. SEX				6. DATE OF BIRTH			
MALE				3-5-89			
7. RACE				9. AGE (In years last birthday)			
WHITE				78			
8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
WIDOWED				LEHIGH VALLEY RAILROAD-BUFFALO, NEW YORK			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
NEW YORK				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
MARTIN Jozwiak				AGNES Smania			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
NONE				715-14-0388			
17. INFORMANT				ADDRESS			
ST. AGNES HOSPITAL RECORDS							
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) ACUTE MYOCARDIAL INFARCTION			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) ARTERIOCLEROTIC CARDIOVASCULAR HEART DISEASE			
ANTECEDENT CAUSES				(C) DIABETES MELLITUS			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
10							
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUNE 6 19 67 to JUNE 8 19 67, that (I) (we) last saw the deceased alive on JUNE 8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
RODOLFO M. REVILLA				6-8-67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
RODOLFO M. REVILLA				21229 ST. AGNES HOSP; CATON & WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				June 13/67			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
St. Adalbert's Cemetery				Buffalo, Erie Co, New York			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
JUN 12 1967				Robert E. Farber			
25C. FUNERAL DIRECTOR				ADDRESS			
Eugene B. Fleming				Singleman Funeral Home Glen Burnie, Md.			

10-5981

JUNE 1, 1967

ST. AGNES HOSPITAL

MARYLAND

CLINTON, MD

121 WILSON RD

ST. AGNES HOSPITAL

MALE WHITE WIDOWED 6-8-33

LEHIGH VALLEY

E.T.A.

RAILROAD - BUFFALO, NEW YORK

RETIRED

NEW YORK

AGNES

MARTIN

ST. AGNES HOSPITAL RECORDS

WIFE

JUNE 1

67

JUNE 8

67

JUNE 10

6-8-33

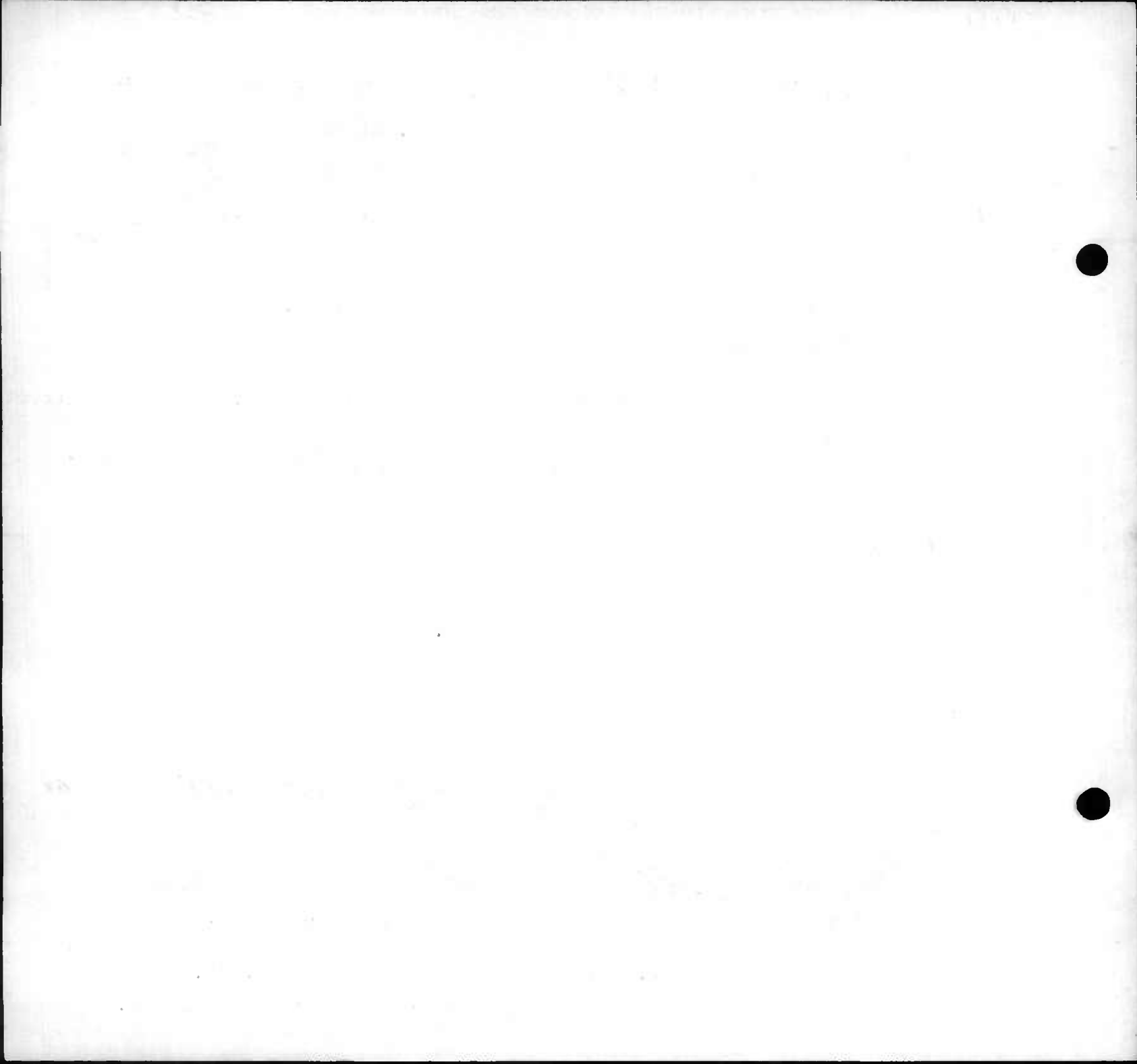
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ST. AGNES HOSP; CATON & WILSON AVE.

Handwritten signature

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5632	
BIRTH NO. 67 5632		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) IDA Jane CONN		2. DATE AND HOUR OF DEATH June 6, 1967 5:20 p M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Gould Nursing Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 21224 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 412 S. East Ave.,		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 2/28/74	9. AGE (In years last birthday) 93	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Arthur Baker			14. MOTHER'S MAIDEN NAME Eliza Hubbard		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 21		16. SOCIAL SECURITY NO. 7-48-4830		17. INFORMANT ADDRESS Delma Kreidwise, dght. 3121 Dillon Street	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) ARTERIOSCLEROTIC C.V.D.S DUE TO (B) _____ DUE TO (C) _____		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/8 19 65 to 6/6 19 67 , that (I) (we) last saw the deceased alive on 6/6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Benjamin Highstein				23B. DATE SIGNED 6/6/67	
23C. PHYSICIAN'S NAME (Type) Benjamin Highstein		23D. ADDRESS 121 S. Highland Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/10/67		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR E. J. Johnson		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5633	
67 5633 CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
NELSON, Harry Edward Sr.			June 5, 1967 7:45 p M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
90 Gould Nursing Home			Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			4224 Soth Avenue, Balto., Md. 21236		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
male	white	widowed	3/12/1885	82 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Machinist		Koppers Co.		Baltimore, Md.	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Henry Nelson			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		212-07-5365		Harry Nelson Jr., son, above	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) Carcinoma of prostate with		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			DUE TO		
ANTECEDENT CAUSES			(B) widespread metastasis		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from X DEC 1962 to June 1967, that (I) (we) last saw the deceased alive on June 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Charles Kerr M.D.				June 7, 67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Charles Kerr		6801 Belair Road (Overlea)			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	6/9/67	Parkwood Cemetery		Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 12 1967		Robert E. Finkbeiner		Schimunek Funeral Home 3331 Brehms Lane #13	

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X DEC

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5634		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5634	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) NORRIS; HOWARD RUSSELL			2. DATE AND HOUR OF DEATH JUNE 6TH 1967 530 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 44			A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-02 D. STREET ADDRESS (If rural, give location) 4362 PARKSIDE DRIVE		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 01-01-05	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus driver		10B. KIND OF BUSINESS OR INDUSTRY Balto. Transit		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.	
12. CITIZEN OF WHAT COUNTRY? AMERICAN			13. FATHER'S NAME Norris Howard William		
14. MOTHER'S MAIDEN NAME Minerva Infield			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 213-10-1345			17. INFORMANT ADDRESS Helen Jaworski Norris, wife, above		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION 12 hours Arteriosclerotic cardio-vascular disease					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-6 4PM 67 to 6-6 530 PM 67 , that (I) (we) last saw the deceased alive on 6-6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fredtjofur Bjornson M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 6-6 67	
23C. PHYSICIAN'S NAME (Type) FRIDTJOFUR BJORNSSON				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/10/67		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			
25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane			

25 20-10-10 James White

13th Avenue
North Mount Wilson
MINERS
Infectia

MYOCARDIAL INFARCT (12 hours)

Photographic Lab -
Hawthorne House

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FRIDTIC FUR BUCHSEN

10-2-2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5635	
67 5635 CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Michael Thomas Novak</i>	
2. DATE AND HOUR OF DEATH <i>June 5 1967 - 4 P.M.</i>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>77 Mercy Hospital</i>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto 27-09</i>			
D. STREET ADDRESS (If rural, give location) <i>1386 Pentwood Rd #12</i>		5. SEX <i>m</i> 6. RACE <i>w</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>N.M.</i>			
8. DATE OF BIRTH <i>9-18-51</i> 9. AGE (In years last birthday) <i>9</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i> 10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>			
11. BIRTHPLACE (State or foreign country) <i>Balto.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Francis Novak</i>			14. MOTHER'S MAIDEN NAME <i>Marlene Mitchem</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>np</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT ADDRESS <i>Francis Novak, father, above</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO <i>Pneumonia - probable Sept</i> (B) DUE TO <i>Hydrocephalus c brain damage</i> (C) <i>II</i>					
INTERVAL BETWEEN ONSET AND DEATH					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2-2-67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>none</i>		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 31 1967</i> to <i>June 5 1967</i> , that (I) (we) last saw the deceased alive on <i>June 5 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. E. Schwartz</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>6/6/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>W. E. Schwartz</i>				23D. ADDRESS <i>Mercy Hospital Balto.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/8/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Balto., Md.</i>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 12 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home</i>	
25D. ADDRESS <i>3331 Brehms Lane #13</i>					

James E. Smith
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5-547
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5636				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5636	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MICHAEL JOSEPH SMOLLEY				2. DATE AND HOUR OF DEATH 6-7-67 4:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21214 D. STREET ADDRESS (If rural, give location) 2909 SOUTHERN AVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 9-2-22	9. AGE (In years lost, birthday) 44	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10B. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN Smolley				14. MOTHER'S MAIDEN NAME MARY VAVERCHACK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. 198-14-2377		17. INFORMANT ADDRESS Mr. John Smolley, Elmhurst, New York.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Rheumatic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 20 yrs				19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Rheumatic Fever 30 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 6-6-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED M, MS, AI, AS		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5-10-67 to 6-7-67, that (I) (we) last saw the deceased alive on 6-7-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE L C Parks MD				23B. DATE SIGNED 6-7-67		23C. PHYSICIAN'S NAME (Type) Leon C Parks	
23D. ADDRESS Johns Hopkins Hosp				23E. NAME OF REGISTRAR Leonard J. Ruck, Inc. Balto. @21214			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/67		24C. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		24D. LOCATION (City, town, or county) (State) Balt. Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc. Balto. @21214		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. @21214		25D. ADDRESS	

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5637

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

SUSIE

B.

JONES

2. DATE AND HOUR PRONOUNCED DEAD

June 5, 1967

2:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1743 E. 25th Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2786 Tivoloy Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9-10-1915

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Demester

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles Royster

14. MOTHER'S MAIDEN NAME

Fannie Royster

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Fannie Royster 1631 E North ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and Hypertensive
Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

6/6/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

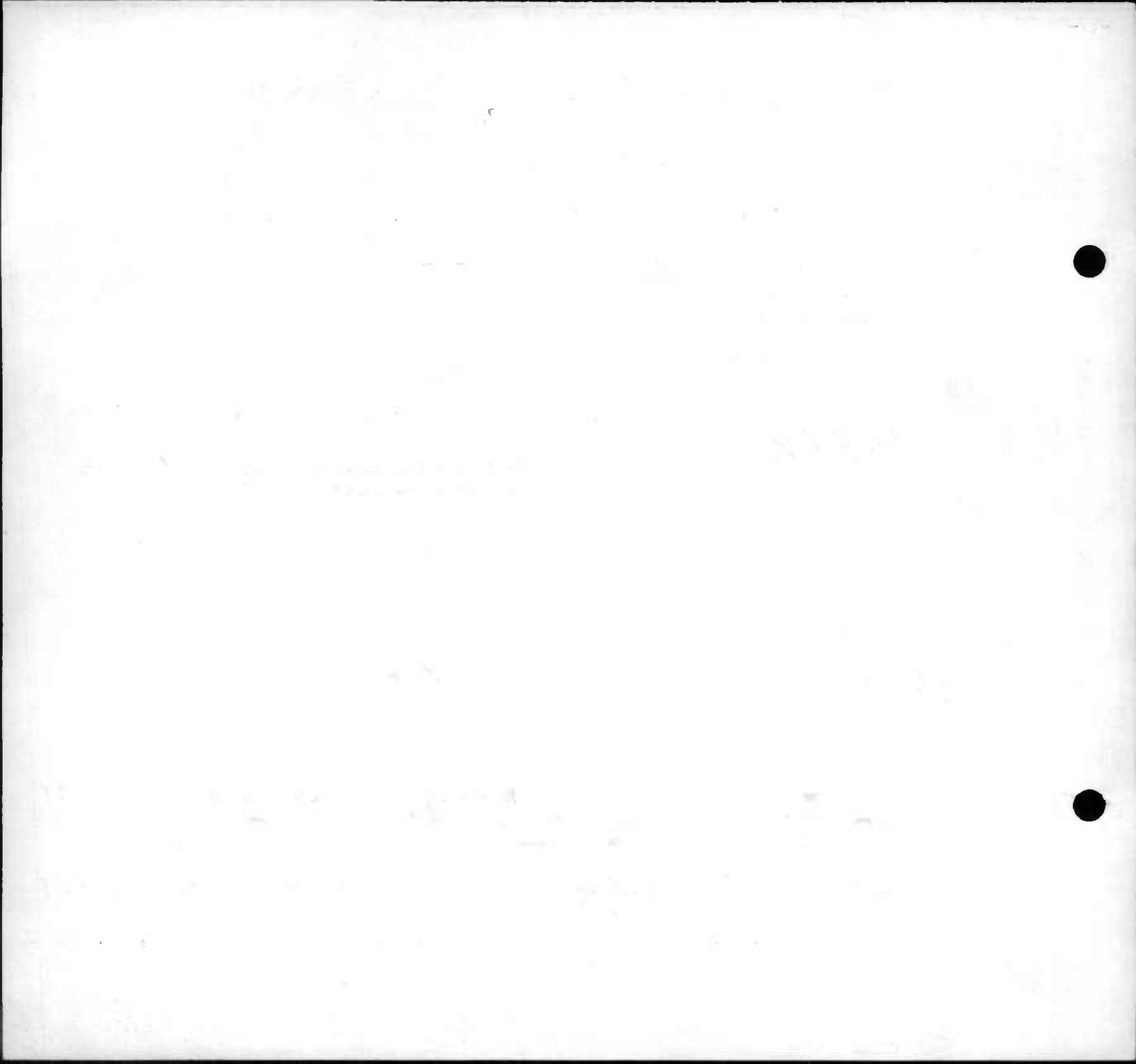
24C. FUNERAL DIRECTOR

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

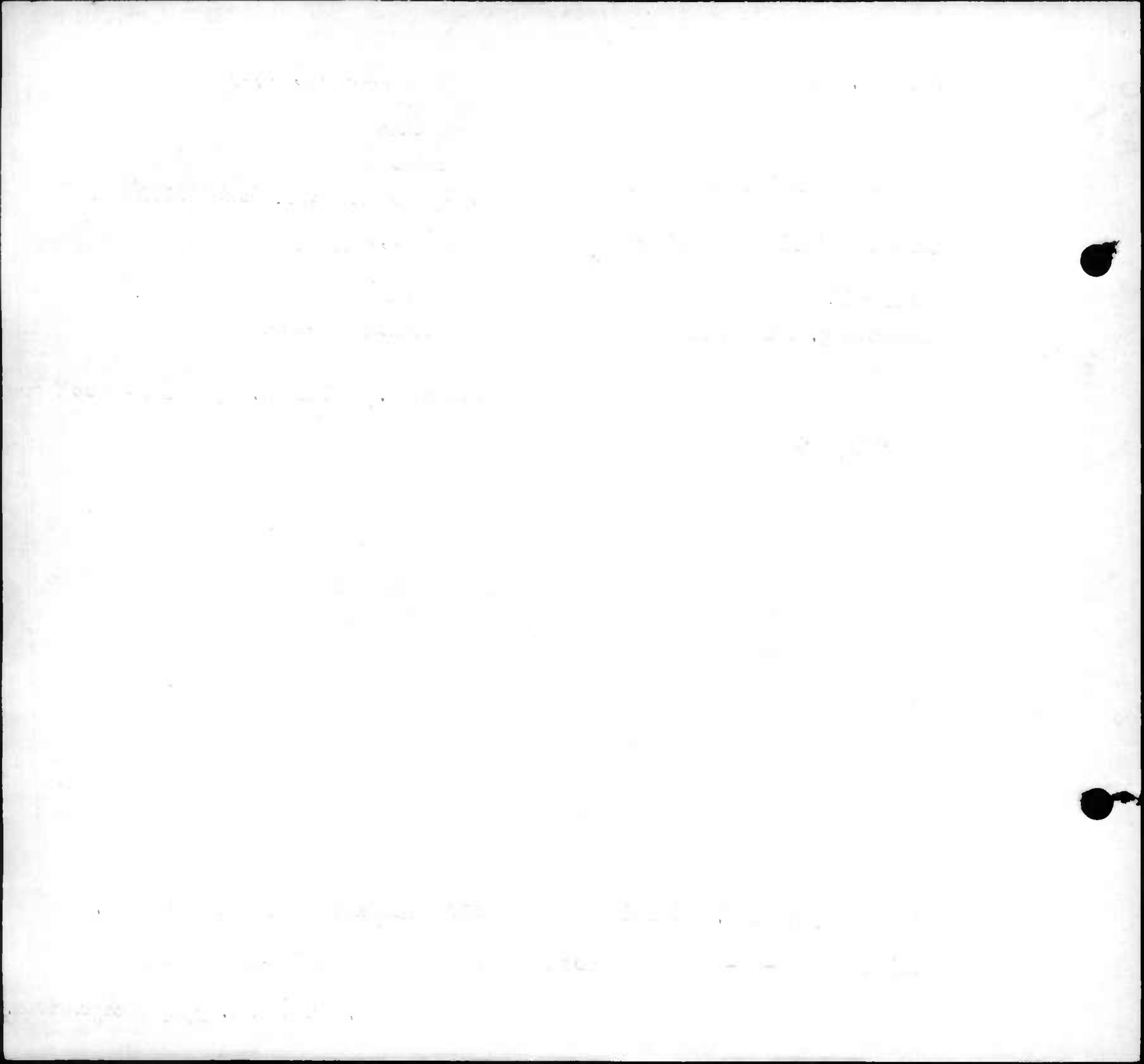
BIRTH NO. 100-340		67 5638		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5638	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>Mary E. Whittle</u>			
2. DATE AND HOUR OF DEATH <u>6 June 1967</u>				7 ⁰⁰ P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u>				A. STATE <u>Maryland</u>			
<u>31</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland #21224</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>417 E. Lanvale St. #21202</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>5-16-04</u>	9. AGE (In years lost birthday) <u>63</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charles Mc Norton</u>			14. MOTHER'S MAIDEN NAME <u>Mary McNorton Morrison</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>BCH 4940 Eastern Avenue</u> <u>RECORDS: Baltimore, Maryland #21224</u>		
18. <u>170X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic carcinoma of the breast</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
INTERVAL BETWEEN ONSET AND DEATH <u>14 mos</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from <u>16 May</u> 19 <u>67</u> to <u>6 June</u> 19 <u>67</u> , that (I) was last saw the deceased alive on <u>6 June</u> 19 <u>67</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Alan J. Barnes</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6 June 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>Alan J. Barnes</u>				23D. ADDRESS M.D. <u>4940 Eastern Avenue Baltimore, Md. #21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Shipped 6-9/67</u>		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <u>Chatham Virginia</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Raymond Sanders 217 E. Preston St. 517 Preston St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

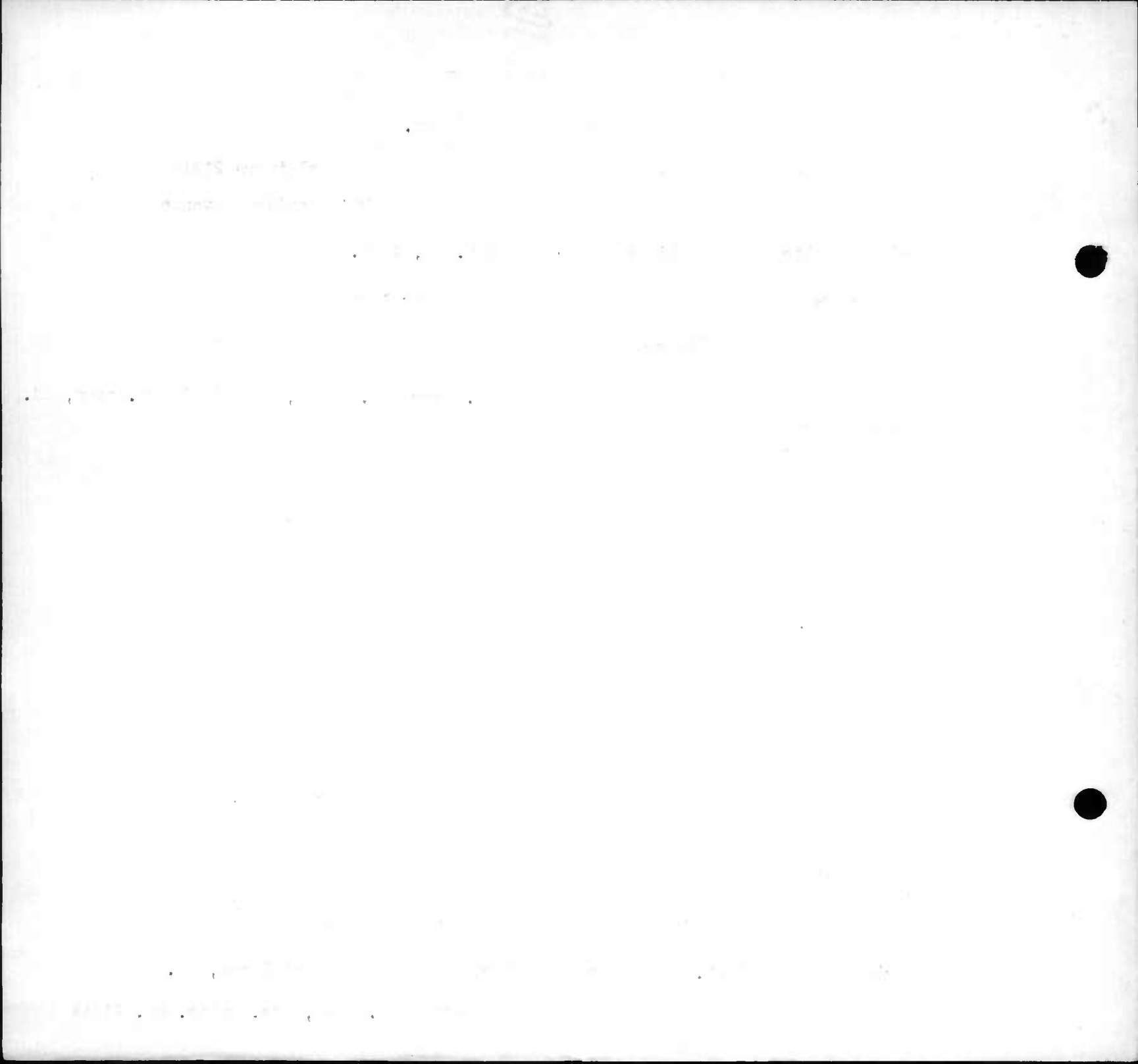
BIRTH NO. 67 5639				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5639	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Helen M. Smith</i>				2. DATE AND HOUR OF DEATH <i>June 10, 1967</i>		10:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If net in hospital or institution, give street address or location) <i>44 Union Memorial Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>27-09 1623 Northbourne Road 21212</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER/MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>April 8, 1897</i>	9. AGE in years Last birthday	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Leonard E. Plaesser</i>				14. MOTHER'S MAIDEN NAME <i>Eleonor Dankweyer</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Herman A. Smith Jr.</i>		ADDRESS <i>2708 Fleetwood Ave.</i>	
18. <i>443 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Cerebral Hemorrhage</i> DUE TO (B) <i>Atherosclerotic cardiovascular disease with hypertension</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>10 hours</i> <i>6 years</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (netely medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>January 22</i> 19 <i>62</i> to <i>June 10</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>June 6</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Edward J. Alessi</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stet. Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6/14/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Edward J. Alessi</i>				23D. ADDRESS <i>6217 Harford Road Baltimore Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-14-67</i>		24C. NAME of CEMETERY or CREMATORY <i>Parkwood</i>		24D. LOCATION (City, town, & county) (State) <i>Baltimore Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 12 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Sanderson</i>		25C. FUNERAL DIRECTOR <i>Leopold J. Ruck Inc.</i>		ADDRESS <i>5305 Harford Rd.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5640		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5640	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) MARY J. BEATY			JUNE 10, 1967 8:06 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium			A. STATE Md. B. COUNTY		
5. SEX Female			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21214		
6. RACE White			D. STREET ADDRESS (If rural, give location) 3912 Hamilton Avenue		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed			8. DATE OF BIRTH Feb. 22, 1894.		
9. AGE (In years lost birthday) 73			10. BIRTHPLACE (State or foreign country) Maryland		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME ? Stefan			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Mr. George W. Beaty, 529 Trimble Rd. Joppa, Md.			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 334X1			CAUSE OF DEATH (A) Severe arteriosclerotic DUE TO cardio-vascular disease with dehydration (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 5 years or more		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from December 1966 to June 10 1967 , that (I) (we) lost saw the deceased alive on June 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. A. de Guzman			23B. DATE SIGNED June 10, 1967		
23C. PHYSICIAN'S NAME (Type) B. A. de GUZMAN			23D. ADDRESS 1013 OLD NORTH POINT RD. BALTO., MD. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 6/13/67.		
24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			25B. NAME OF REGISTRAR Robert E. Taylor		
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5641	
BIRTH NO. 67 5641		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) RICHARD P. SOWERS		6-9-67 7-30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33		A. STATE VA B. COUNTY Chesterfield	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) RICHMOND V-43	
		D. STREET ADDRESS (If rural, give location) 10250 CHEROKEE ROAD	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-3-12
		9. AGE (In years lost birthday) 55	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) attorney & Asso. Judge		10B. KIND OF BUSINESS OR INDUSTRY Chesterfield Co, Va.	
11. BIRTHPLACE (State or foreign country) Richmond, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME R. P. SOWERS		14. MOTHER'S MAIDEN NAME CHRISTINE Mc DONALD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II USAF		16. SOCIAL SECURITY NO.	
17. INFORMANT Joseph W. Bliley Co.		ADDRESS 300 E. Marshall St. Richmond, Virginia	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 157X1		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Cardiac arrest - 2° hypertension	
		(B) DUE TO Pancreaticoduodenal stenosis 18 hours	
		(C) B-cell adenoma of the pancreas 23 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Extreme obesity	
19A. DATE OF OPERATION 6/8/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED B-cell adenoma of pancreas	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/6/67 19 to 6/9/67 19, that (I) (we) last saw the deceased alive on 6/9/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William B. Iams M.D.		23B. DATE SIGNED 6/9/67	
23C. PHYSICIAN'S NAME (Type) WILLIAM B. IAMS		23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 6-13-67	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Richmond Virginia	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Lehard J. Ruck		ADDRESS Inc. - Baltimore, Md. 14	

100507
FOREIGN DISBURSEMENTS

THE JOHN HOPKINS HOSPITAL RICHMOND
10220 CHESTER ROAD
VA
MARCH 22 2-3-12

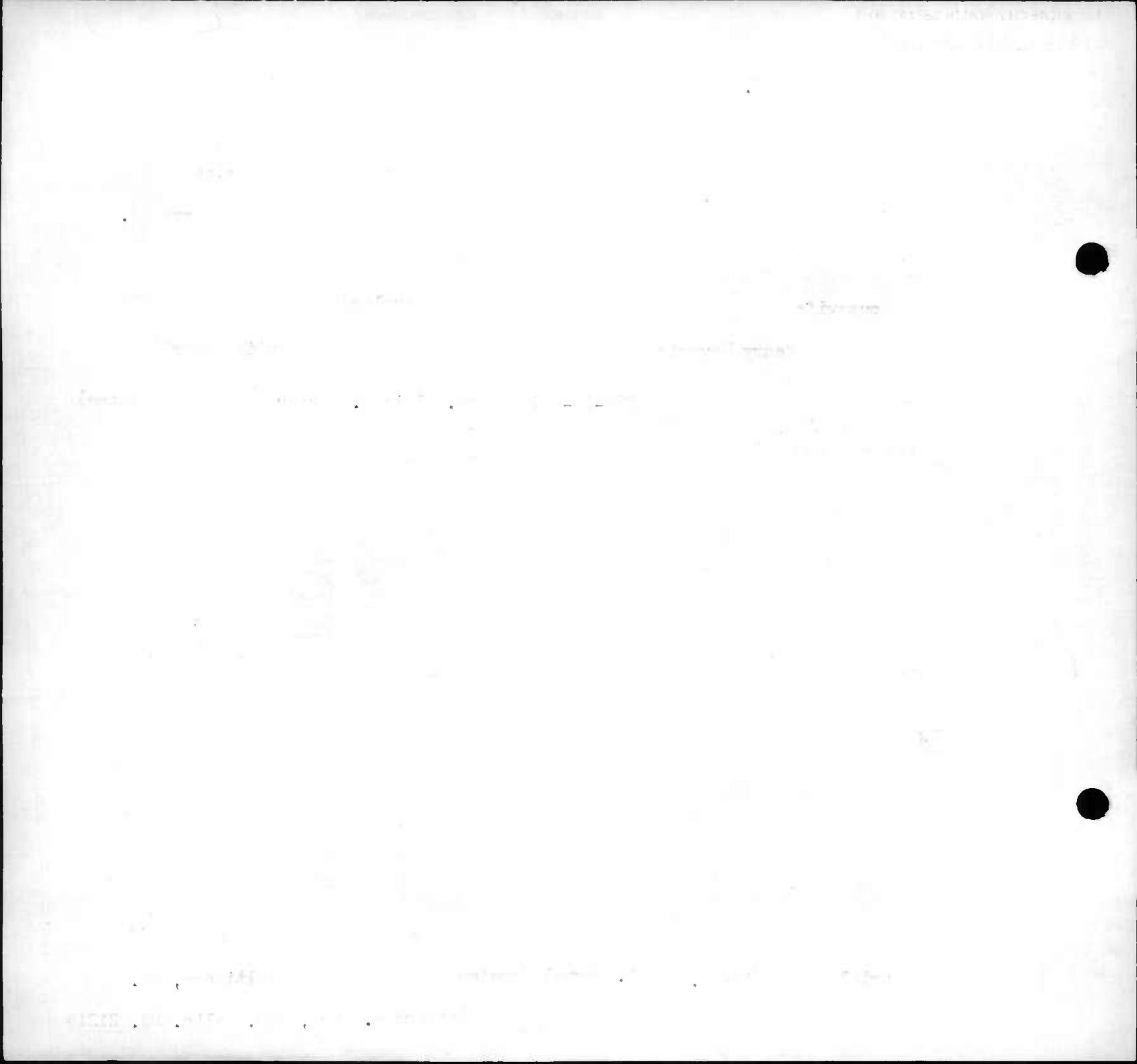
R. F. JONES
CHRISTINE M. DONARD

WILLIAM S. JAMES
JOHN HOPKINS HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5642	
BIRTH NO. 67 5642					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Emma J. McKay			2. DATE AND HOUR OF DEATH June 9th 1967 10:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Sinai Hospital of Baltimore FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-09		
5. SEX F			6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Wid
8. DATE OF BIRTH 4/11/81			9. AGE (In years last birthday) 86		10. If Under 1 Yr. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Henry Weyerich			14. MOTHER'S MAIDEN NAME Julia Franski		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-18-4874D		17. INFORMANT Mrs. Elsie C. Werner
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO CVA (B) DUE TO Prob Embolus (C) DUE TO ASCVD INTERVAL BETWEEN ONSET AND DEATH 1 hour Unknown Unknown					
19. DATE OF OPERATION 6/8/67			20. AUTOPSY? (Yes or No)		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22. I certify that (I) (this hospital) attended the deceased from 6/8/67 to 6/9/67, that (I) (we) last saw the deceased alive on 6/9/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED 6/9/67		
23C. PHYSICIAN'S NAME (Type) William Cieplinski			23D. ADDRESS Sinai Hospital of Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 6/13/67		24C. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery
24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214

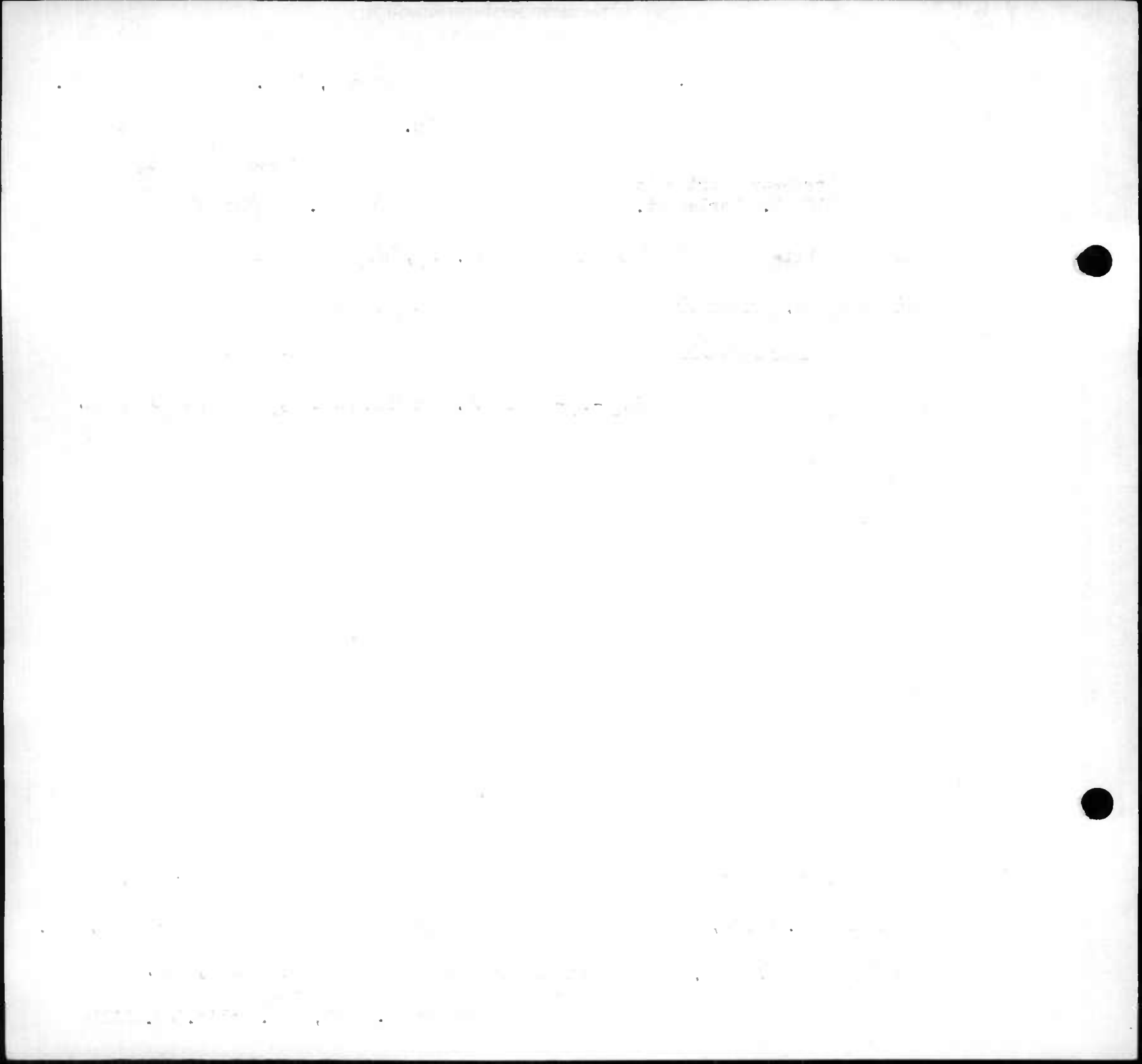


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 5643	
CERTIFICATE OF DEATH				Registered No. 67 5643	
BIRTH NO. 67 5643		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Wilhelmina (Minnie) McClelland	
2. DATE AND HOUR OF DEATH June 4/8/67 4:30 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Baltimore		5. SEX F. 6. RACE W. 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed			
8. DATE OF BIRTH 3-16-78 9. AGE (In years last birthday) 89		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Miller	
14. MOTHER'S MAIDEN NAME Eckles		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-48-2586	
17. INFORMANT Mrs. Naomi Markiewicz, 3126 Northway Dr.		18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) DUE TO Carcinoma of breast		(B) DUE TO		(C) DUE TO	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		ANTECEDENT CAUSES		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 3rd 1967 to June 4th 1967 and that (I) (we) last saw the deceased alive on June 3rd 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE George H. Beck		23B. DATE SIGNED 6/8/67	
23C. PHYSICIAN'S NAME (Type) George H. Beck		23D. ADDRESS 6012 Harford Rd. Baltimore, Md 21214		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 6-12-67		24C. NAME OF CEMETERY or CREMATORY Baltimore		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Reuben E. Taylor, Jr.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5644		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 5644	
1. NAME OF DECEASED (Type or Print) CHARLES E. NOLTE			2. DATE AND HOUR OF DEATH June 8, 1967. 4 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Northway Apartments 3700 N. Charles St.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3700 N. Charles ST		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 19, 1883	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Corp. Executive			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Fred Nolte		
14. MOTHER'S MAIDEN NAME Dena Wilke			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 215-09-4308			17. INFORMANT ADDRESS Mr. August Nolte, 5436 Harford Rd.		
18. I 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 minutes years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 6 19 61 to 6/8 19 67 , that (I) (we) last saw the deceased alive on 6/7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE William F. Fritz M.D.				23B. DATE SIGNED June 9, 1967	
23C. PHYSICIAN'S NAME (Type) WILLIAM F. FRITZ,				23D. ADDRESS M.D. 2 West University Parkway-Balto 21218, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/67.		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			
25B. NAME OF REGISTRAR Edw. E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Buck, Inc. Balto. Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5645	
BIRTH NO. 67 5645		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARGARET STADLER		2. DATE AND HOUR OF DEATH 6/9/67 5:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME AND HOSPITAL		A. STATE MARYLAND B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21205			
		D. STREET ADDRESS (If rural, give location) 4810 ERDMAN AVE.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-31-1908	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME HENRY SCHGIDER		14. MOTHER'S MAIDEN NAME EMMA EHOFF	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Mr. Rudolph Stadler	
				ADDRESS (Same)	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION HOURS		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) MYOCARDIAL INFARCTION HOURS			
		(B) ARTERIOSCLEROTIC HEART DISEASE YEARS			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-8 1967 to 6-9 1967 , that (I) (we) last saw the deceased alive on 6-9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francisco Daltazar				23B. DATE SIGNED 6/9/67	
23C. PHYSICIAN'S NAME (Type) FRANCISCO DALTAZAR, M.D.				23D. ADDRESS CHURCH HOME & HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/13/67		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Leonard J. Ryck, Inc. Balto. Md. 21214			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5646	
BIRTH NO. 67 5646		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LATTANZI, EMIL J.		2. DATE AND HOUR OF DEATH 3:50 pm June 10, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3134 Berkshire Rd			
5. SEX M	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 12-27-17	9. AGE (In years lost birthday) 49	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Sales Dept.		10B. KIND OF BUSINESS OR INDUSTRY O'BRIEN PRINT		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME DOMINIC LATTANZI		14. MOTHER'S MAIDEN NAME Laura Gamberdelle	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-0928		17. INFORMANT ADDRESS Dolores E. Lattanzi, 3134 Berkshire Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		CAUSE OF DEATH Arteriosclerosis CVD		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 11:45 AM, June 3, 1967 to 3:50 PM June 10, 1967 , that (I) <u>(we)</u> last saw the deceased alive on 3:50 pm June 10, 1967 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE Sang Won Song		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 10, 1967	
23C. PHYSICIAN'S NAME (Type) SANG WON SONG		23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (specify) Burial		24B. DATE 6-14-67		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Buck, Inc., 5305 Harford Rd.			

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Examination

The Union Memorial Hospital 31st & Gessetown Rd

12-17-74

M 10:30 AM

GREEN PRINT

Examination

ANDY CAMBERDELL

DOMINIC LATANSI

Myocardial Infarction

Arteriosclerosis CVD

3:00 PM 11-10-74
11:45 AM 11-10-74
3:00 PM 11-10-74

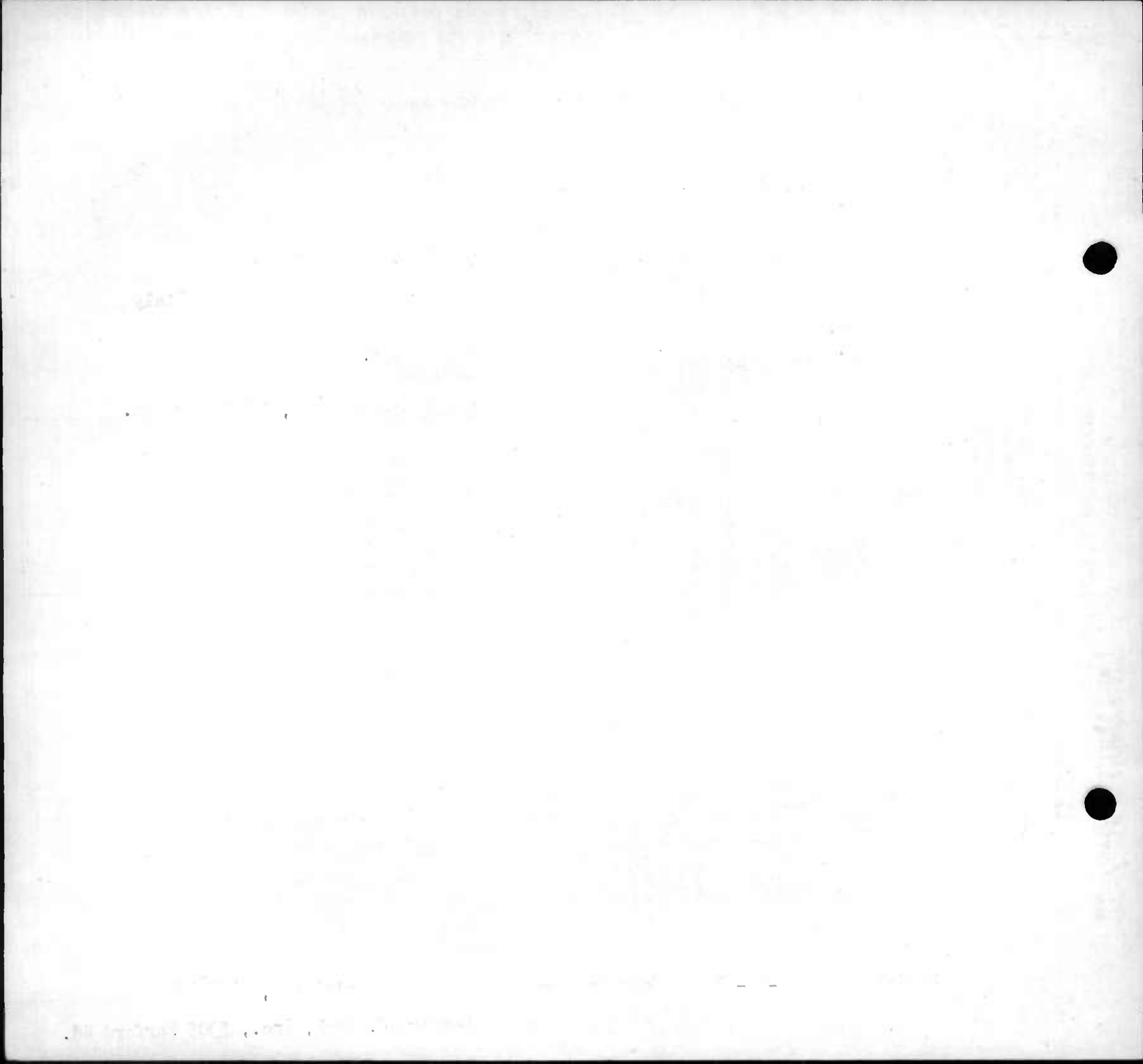
Handwritten signature

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5647</u>	
67 5647 CERTIFICATE OF DEATH					
BIRTH NO. <u>67 5647</u>		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>NICHOLAS J. SPINNATO</u>			2. DATE AND HOUR OF DEATH <u>6-11-67</u> <u>10¹⁵ A.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 MARYLAND GENERAL HOSP</u>			A. STATE <u>MD</u> B. COUNTY		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
			D. STREET ADDRESS (If rural, give location) <u>1623 Gough St</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>6-8-88</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>
13. FATHER'S NAME <u>MICHAEL SPINNATO</u>			14. MOTHER'S MAIDEN NAME <u>CATHERINE MARIANNA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>ANNA SPINNATO, 1623 Gough St.</u>		
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Asystole</u> DUE TO (B) <u>Myocardial infarction</u> DUE TO (C) <u>Coronary atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>10 days</u> <u>Unknown</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-4</u> 19 <u>67</u> to <u>6-11</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-11</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Timothy K. Gray</u> M.D.				23B. DATE SIGNED <u>6-11-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>TIMOTHY K. GRAY</u> M.D.				23D. ADDRESS <u>Maryland General Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-14-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 12 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MA</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Buck, Inc., 5305 Harford Rd.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5648	
67 5648				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		Rose G. Gough		2. DATE AND HOUR OF DEATH 6/10/67 9P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hosp. Maryland Gen Hospital.		A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. STREET ADDRESS 5620 Belair Rd			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Unmarried	8. DATE OF BIRTH 8-2-04	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Wife		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Kennedy, Dennis		14. MOTHER'S MAIDEN NAME Mary E. Connor	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) X No		16. SOCIAL SECURITY NO. 219-14-1592		17. INFORMANT Dolores Gough, 5005 Raintree Way	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) MASSIVE Peritonitis		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Perforated Ulcer					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. RENAL Failure					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/22 1967 to 6/10 1967, that (I) (we) last saw the deceased alive on 6/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel C. Wilkerson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/10/67	
23C. PHYSICIAN'S NAME (Type) Daniel C. Wilkerson		23D. ADDRESS 421 Regester Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-15-67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			
25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd			

Page 7 Group

File 127

47

and Gault

Wicks

2500 Galtier Rd

10-01 125

and

Washington State Hospital

W. W. Wicks

Wicks

Removal

214-14-1275

File 127

2175

File 127

David G. Wicks

David G. Wicks

David G. Wicks

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67. 5649				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5649	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) HAZEL L. MUNDEY			
2. DATE AND HOUR OF DEATH 6/11/67 10⁰⁰ A. M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Mem. Hosp. 33rd & N Calvert St.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE.			
D. STREET ADDRESS (If rural, give location) 815 E. Evesham Ave.							
5. SEX Female	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 5/29/95	9. AGE (In years last birthday) 72	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Housewife			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) USA - Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME J. M. Morhiser			14. MOTHER'S MAIDEN NAME Addie Ball				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. —		17. INFORMANT Doris E. Phelps		
					ADDRESS Daughter 815 E. Evesham Ave.		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ante myocardial infarction				CAUSE OF DEATH (A) DUE TO Coronary arterio sclerosis			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO —			
(C) DUE TO —				INTERVAL BETWEEN ONSET AND DEATH —			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? —		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 6/7/67 19 67 to 6/11 19 67 , that (I) (we) last saw the deceased alive on 6/11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE DR. ROBERT P. DOYLE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/11/67	
23C. PHYSICIAN'S NAME (Type) DR. ROBERT P. DOYLE				23D. ADDRESS THE UNION MEMORIAL HOSPITAL Union Memorial Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-15-67		24C. NAME OF CEMETERY or CREMATORY Lorraine Pk.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Sisk		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.			

HAZEL MICH DEY

6/11/67 10:00

1109 BATTIMORE
BATTIMORE
815 EUSHAM AVE

33rd N. Calvert St.
Union Town Hall

Frank Connerin married. 2/29/62 72

02A - MB
A215

More Hizer married
None

Double for

First independent information
many other cases

1/6

6/15/67

6/11

John V. Deane

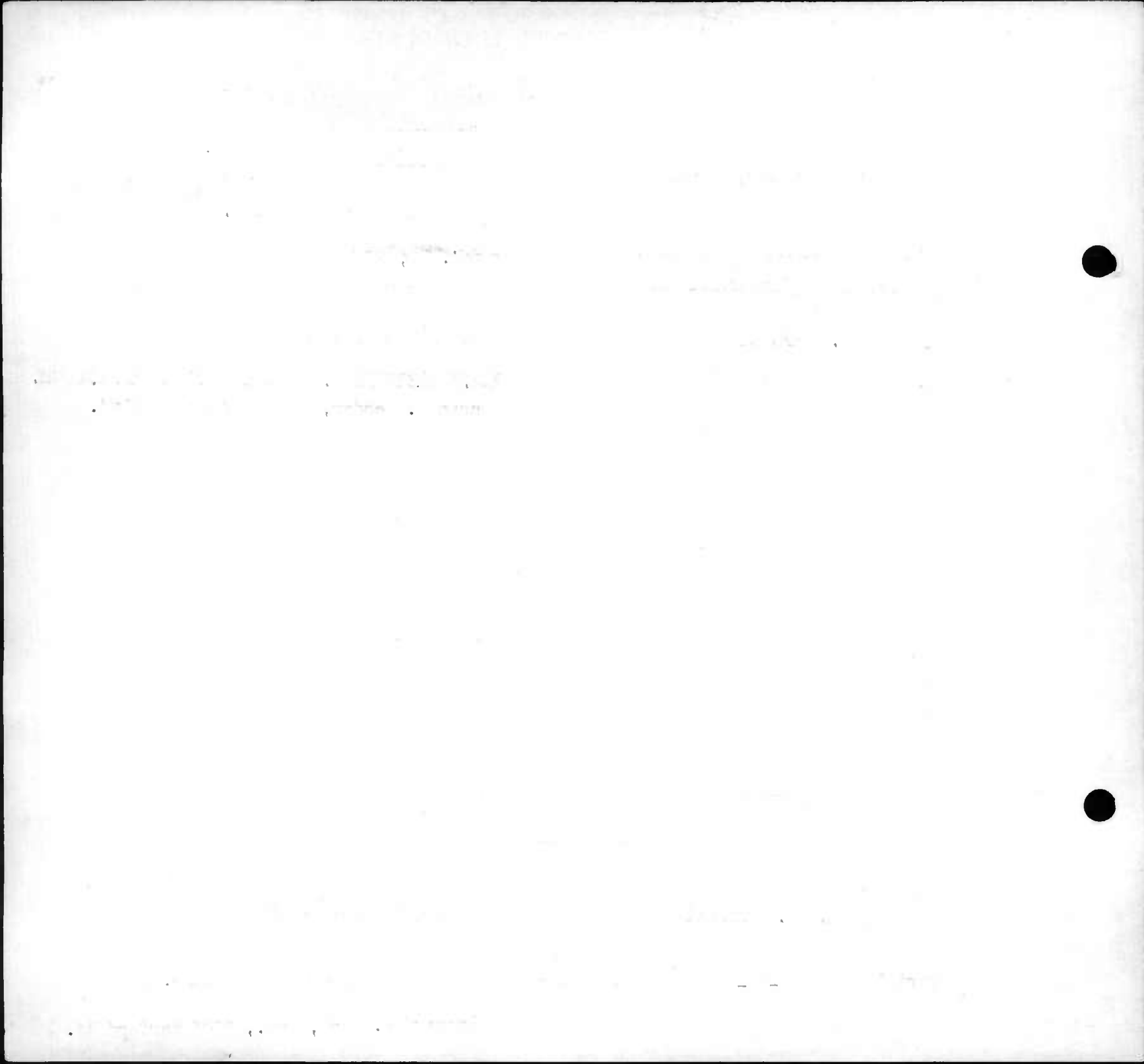
Union Memorial Hall

6/11/67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

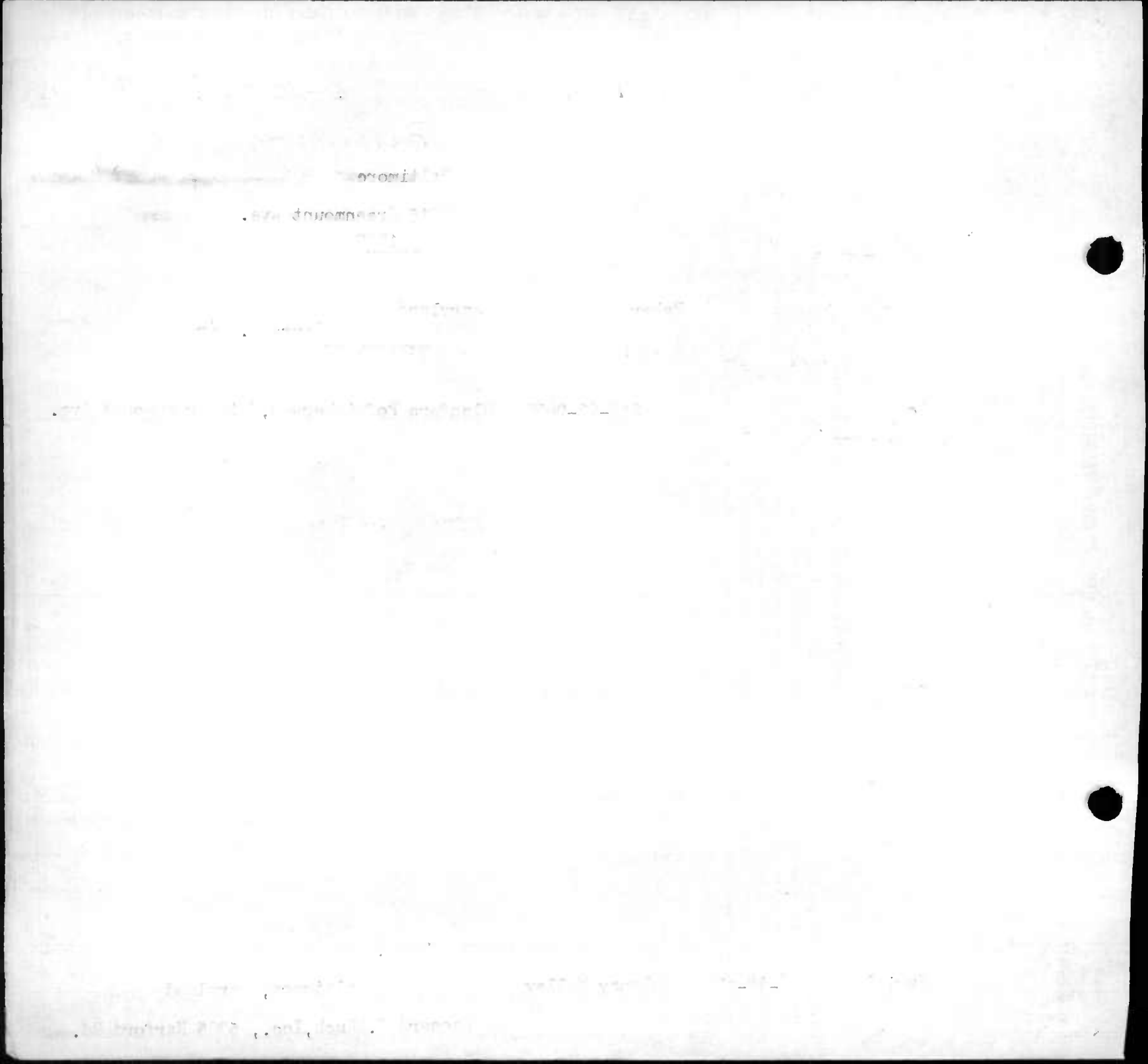
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5650	
CERTIFICATE OF DEATH					
BIRTH NO. 67 5650					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) CLIFFORD CHARLES BENDER		2. DATE AND HOUR OF DEATH June 11, 1967 13:15 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium		A. STATE Maryland			
		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-38			
		D. STREET ADDRESS (If rural, give location) 5624 Loch Raven Blvd.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED Single	8. DATE OF BIRTH Feb. 23, 1901	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done before and during life, as well as retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Employee National Brewery		National Brewery		Maryland	
13. FATHER'S NAME Frank J. Bender			14. MOTHER'S MAIDEN NAME Sophia Hohbein		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. Informant's Name and Address (If deceased, give name and address of informant) Susan C. Bender, 5624 Loch Raven Blvd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 420.141 163 X		CAUSE OF DEATH (A) Pulmonary Edema DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Coronary Artery Disease DUE TO		5 years	
		(C) Arteriosclerosis		5 years	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma Left Lung		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		19C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb. 19 62 to June 11, 19 67 , that (I) (was) last saw the deceased alive on June 10, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE Michael J. Dausch				23B. DATE SIGNED June 11, 1967	
23C. PHYSICIAN'S NAME (Print) Michael J. Dausch		23D. ADDRESS 4636 Belair Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-14-67		24C. NAME of CEMETERY or CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			
25B. NAME OF REGISTRAR R. E. E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 5651		CITY HEALTH DEPARTMENT		Registered No. 67 5651	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>Charles Poffinberger</u>			
2. DATE AND HOUR OF DEATH <u>6-10-67</u> <u>2:10</u> P.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Baltimore md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2715 Greenmount Ave.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>		(If not in hospital or institution, give street address or location)		5. SEX <u>M</u>		6. RACE <u>W</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>M</u>		8. DATE OF BIRTH <u>1889</u>		9. AGE (In years last birthday) <u>77</u>		10. If Under 1 Yr. Months Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Baker</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Poffinberger</u>				14. MOTHER'S MAIDEN NAME <u>Laura E. Harp</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-0479</u>		17. INFORMANT <u>Glendora Poffinberger</u>		ADDRESS <u>2715 Greenmount Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>162.1 I</u> <u>Pulmonary Failure</u> <u>Brachogenic CA</u> <u>Smoking</u> INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Urinary Tract Infection</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5-9</u> 19 <u>67</u> to <u>6-10</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-10</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Michael A. Ellis</u> M.D.				23B. DATE SIGNED <u>6-10-67</u>			
23C. PHYSICIAN'S NAME (Type) <u>Michael A. Ellis</u> M.D.				23D. ADDRESS <u>Mercy Hospital Baltimore Md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-14-67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>JUN 12 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Sisk</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc., 5305 Harford Rd.</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5652

BIRTH NO. 67 5652

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN W. ELY Sr.

2. DATE AND HOUR PRONOUNCED DEAD

June 7, 1967

5:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 3319 Liberty Heights

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3319 Liberty Heights AVE.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 1 1907

9. AGE (In years
last birthday)

29 59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Foreman

10B. KIND OF BUSINESS OR INDUSTRY

Post Office

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James H. Ely

14. MOTHER'S MAIDEN NAME

Grace ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

220-12-8121

17. INFORMANT

ADDRESS

John H. Ely, Jr. 8359 Morven Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

June 8, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/10/67

23C. NAME of CEMETERY or CREMATORY

Loudon Pk. Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 12 1967

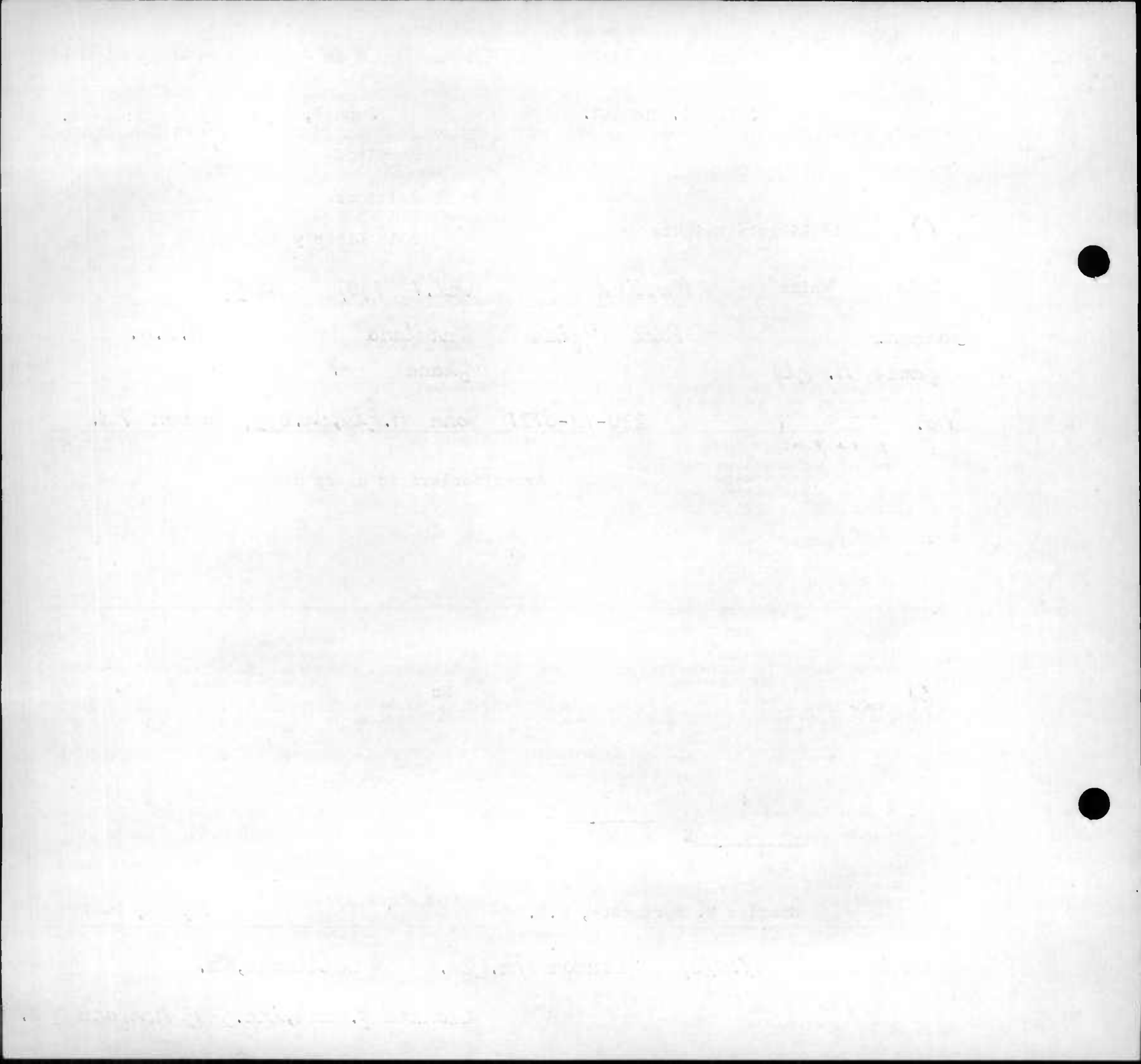
24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, inc. 5305 Harford Rd.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 5653 CERTIFICATE OF DEATH					Registered No. 67 5653					
BIRTH NO.		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
					Manion B. Rogers			June 11 1967 1:50 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hosp. 48					A. STATE Rhode Island					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Berkeley					
					D. STREET ADDRESS (If rural, give location) 1179 Mendon Rd					
5. SEX F	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH 09-28-1893	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Clerk					10B. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (State or foreign country) R.I.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Tennyson					14. MOTHER'S MAIDEN NAME Mary McDermott					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Medical Record			
18. 153.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Carcinoma DUE TO (B) Lung Cancer DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION May 5, 1967			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tumor			20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from April 27 1967 to June 11 1967, that (I) (we) last saw the deceased alive on June 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Gounisik Moon					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED June 11 1967		
23C. PHYSICIAN'S NAME (Type) Gounisik Moon					23D. ADDRESS Maryland General					
24A. BURIAL CREMATION, REMOVAL (Specify) Removal			24B. DATE 6/12/67		24C. NAME OF CEMETERY or CREMATORY St. Joseph Cemetery		24D. LOCATION (City, town, or county) (State) Berkeley, Rhode Island			
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			25B. NAME OF REGISTRAR Robert E. Fagley			25C. FUNERAL DIRECTOR Wm. J. Dickner 1300 Mid 2-12-17				

referred

referred

referred

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 5654

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5655	
BIRTH NO. 67 5655		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Annie E. Crouse		2. DATE AND HOUR OF DEATH June 8, 1967 6:00 P. M.	
3. PLACE OF DEATH BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 90 House in the Pines - Belair		D. STREET ADDRESS (If rural, give location) 1534 McKean Avenue		17	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH May 5, 1886	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles Gore		14. MOTHER'S MAIDEN NAME Emma		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-1430		17. INFORMANT ADDRESS Mrs. Mary A. Coberth 3514 Woodring Ave.	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hepatic Coma		CAUSE OF DEATH (A) Hepatic Coma (B) Metastatic Carcinoma of Liver (C) Adenocarcinoma of Biliary Tract		INTERVAL BETWEEN ONSET AND DEATH 24 hours 3 mos. (known)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 25, 1967 to June 8, 1967 , that (I) (we) last saw the deceased alive on June 6, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 9, 1967	
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley		23D. ADDRESS 4900 Belair Rd. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/1967		24C. NAME OF CEMETERY or CREMATORY Oakwood Cemetery	
24D. LOCATION (City, town, or county) (State) Richmond, Va.					
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR W. J. Tichner Sons	
				ADDRESS Baltimore, Md.	

244
 Hypocrite Cove
 Northwest corner of lake
 (distance of 1000 feet)

✓

Mr. C. B. King

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5656		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 5656	
1. NAME OF DECEASED (Type or Print) TROGLER WILLIAM CHARLES			2. DATE AND HOUR OF DEATH JUNE 7th 1967 205P.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital 44			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 28-04		
			D. STREET ADDRESS (If rural, give location) 4415 Old Frederick Rd		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED Married	8. DATE OF BIRTH 05-01-13	9. AGE (In years last birthday) 54	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rate Clerk		10B. KIND OF BUSINESS OR INDUSTRY Transfer Com.		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Clarence Melvin Trogler		
14. MOTHER'S MAIDEN NAME Ellis Kelly			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 218-09-6723			17. INFORMANT Balto. Md. Mrs. Marie F. Trogler 4415 Old Frederick Rd.		
18. 420.1 4-00201 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE Myocardial INFARCTION MURAL THROMBUS, LEFT VENTRICLE			INTERVAL BETWEEN ONSET AND DEATH AB Jimmy		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CASEOUS TUBERCLE, RIGHT APEX					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-31 19 67 to 6-7 19 67 , that (I) (we) last saw the deceased alive on 6-7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fridtjof Bjornum			23B. DATE SIGNED 6-7-67		
23C. PHYSICIAN'S NAME (Type) Union Memorial Hospital			23D. ADDRESS Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 9, 1967		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR E. Truman Schwab 3512 Frederick Ave. Balto. Md.			

1907

TRUSTED TO THE CHURCH OF JESUS CHRIST OF LATTER DAY SAINTS

WILLIAM

WILLIAM HENRY HARRIS JR. 4412 CUBA STREET N.W. WASHINGTON D.C.

ALL THAT REMAINS OF 22-01-13 24

CLARENCE HENRY HARRIS JR. 4412 CUBA STREET N.W. WASHINGTON D.C.

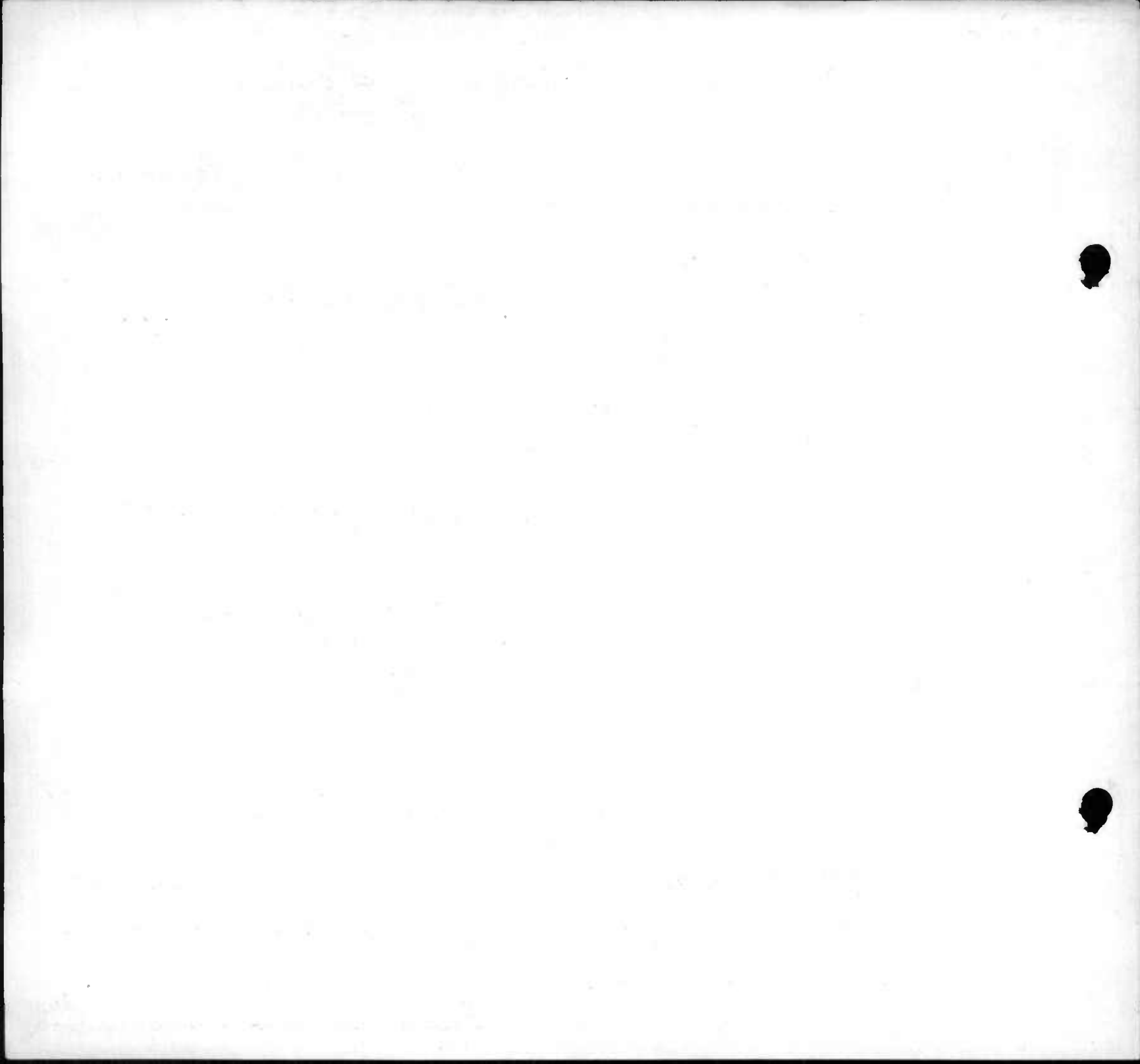
YES

TRUSTED TO THE CHURCH OF JESUS CHRIST OF LATTER DAY SAINTS
WILLIAM HENRY HARRIS JR. 4412 CUBA STREET N.W. WASHINGTON D.C.
4412 CUBA STREET N.W. WASHINGTON D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

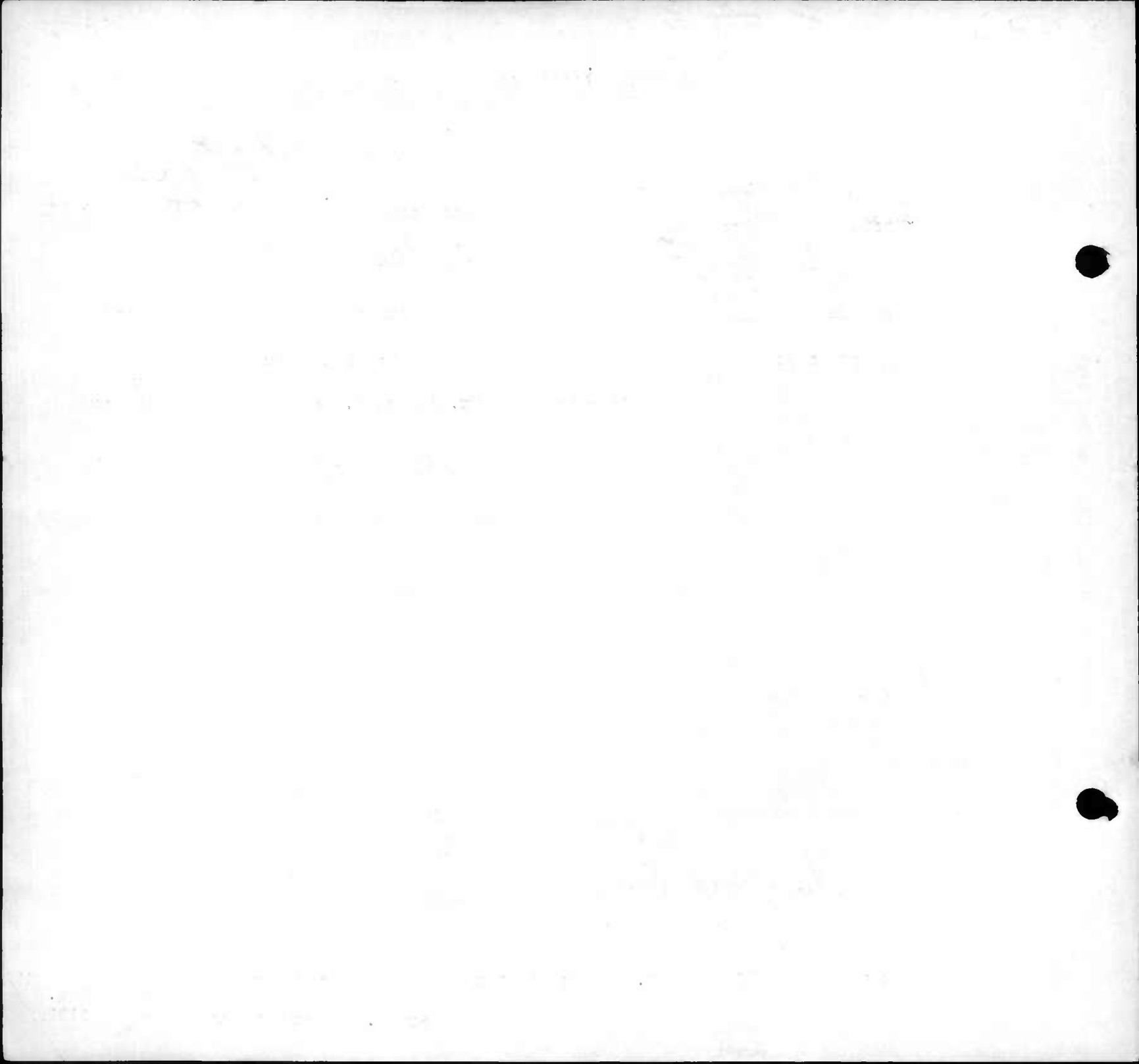
BIRTH NO. 67 5657		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 5657	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HAZEL A Schulze		2. DATE AND HOUR OF DEATH 8 JUNE 67 12:54 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 GOULD'S Convalesarium 6116 Belair Rd Balto 6 Md		A. STATE Md B. COUNTY Baltimore Co.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore RURAL (Rosedale) 53-0			
		D. STREET ADDRESS (If rural, give location) 5701 Hamilton Ave			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 2-7-1898	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production Line		10B. KIND OF BUSINESS OR INDUSTRY Crown Cork Seal Co.		11. BIRTHPLACE (State or foreign country) Philadelphia Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME STRINE		14. MOTHER'S MAIDEN NAME Eisenhart	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-18-0011		17. INFORMANT ADDRESS Mr William Schulze 5701 Hamilton Avenue 6	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 180X I		CAUSE OF DEATH (A) Carcinomatosis DUE TO (B) Origin Probably Renal DUE TO (C) undet.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Atherosclerosis Cardiovascular disease with hypertension			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 1967 to 08 JUNE 1967 , that (I) (we) last saw the deceased alive on 06 June 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John C. Hyle				23B. DATE SIGNED 8 June 67	
23C. PHYSICIAN'S NAME (Type) JOHN C. Hyle				23D. ADDRESS M.D. 7527 Belair Rd Balto 36 Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-10-1967		24C. NAME OF CEMETERY or CREMATORY Moreland Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Folley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Landolt's Funeral Home 2401 Belair Road 36	



FUNERAL DIRECTOR: IMPORTANT

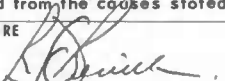

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 5658		CERTIFICATE OF DEATH	
M.E. CASE NO.		Registered No. 67 5658	
1. NAME OF DECEASED (Type or Print) RYAN, EMMA MORRIS		2. DATE AND HOUR OF DEATH June 8, 1967 3:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 36 Franklin Square Hospital		A. STATE MD. B. COUNTY Balto.	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 19-03	
		D. STREET ADDRESS (If rural, give location) 423 PARRISH ST. 21223	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11/7/29
			9. AGE (In years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Haupt		14. MOTHER'S MAIDEN NAME Magdalene Staig	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-7843	
		17. INFORMANT Mr. August J. Haupt ADDRESS Glen Burnie 21061	
		241 Glengary Garth	
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) End Stage of DUE TO (B) metastatic cancer DUE TO (C) from ? to June 8, 67	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 6, 1967 to June 8, 1967 , that (I) (we) last saw the deceased alive on June 8, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Song Bae Na		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Song Bae Na		23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/67	
24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Staley	
25C. FUNERAL DIRECTOR Howard H. Hubbard		25D. ADDRESS 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5659	
BIRTH NO. 67 5659		CERTIFICATE OF DEATH			
M.E. CASE NO.		Willey T.			
1. NAME OF DECEASED (Type or Print)		ODEN, WILKIE/MARRIETT		2. DATE AND HOUR OF DEATH 6-10-67 1:50AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL Caton & Wilkens Ave.				A. STATE MARYLAND B. COUNTY BALTIMORE	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) LANDSOWNE 53-00	
				D. STREET ADDRESS (If rural, give location) 273 CLYDE AVENUE	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 4-5-85	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME J. ANDREW ANDERSON				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218181393		17. INFORMANT ADDRESS ST. AGNES RECORDS-CATON & WILKENS AVES	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PNEUMONITIS ON LEFT LUNG					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 9, 1967 to JUNE 10, 1967 , that (I) (we) lost saw the deceased alive on JUNE 10, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 6/10/67	
23C. PHYSICIAN'S NAME (Type) R.M. REVILLA				23D. ADDRESS ST. AGNES HOSPITAL-CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR 		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard F. H. 4107 Wilkens Ave 21229	

3-10-47
JULIE WILHELMINE HARRIS

MARYLAND

WILMINGTON

215 21 7 AVENUE

4-2-47

1111 11A

MARION WHITE TV

WILHELMINE HARRIS

REAR WILHELMINE HARRIS

REAR WILHELMINE HARRIS

REAR WILHELMINE HARRIS

REAR WILHELMINE HARRIS

REAR WILHELMINE HARRIS

NO

REAR WILHELMINE HARRIS

REAR WILHELMINE HARRIS

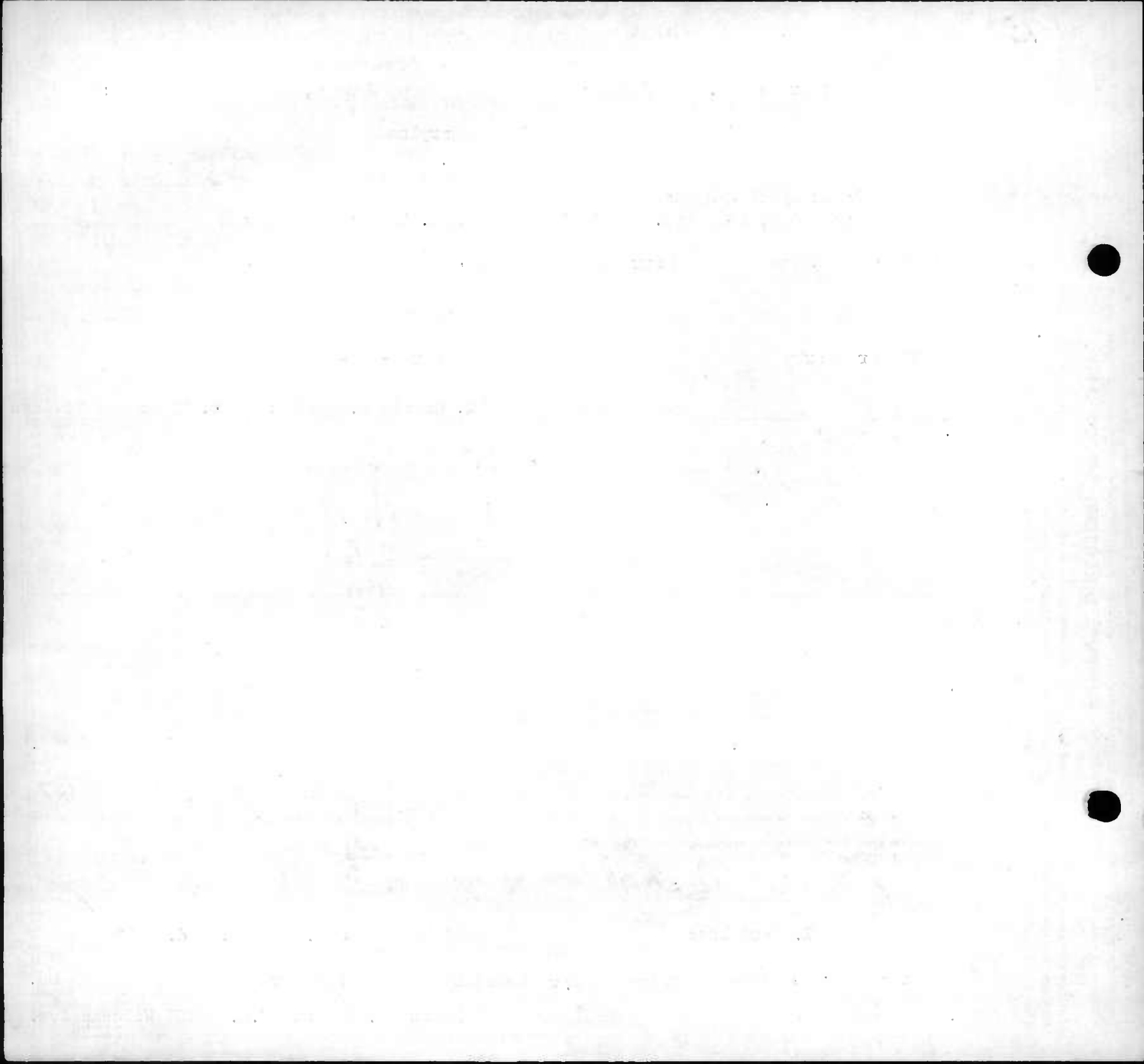
NO

WILHELMINE HARRIS

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5660	
BIRTH NO. 67 5660		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Katherine D. Spellman			
2. DATE AND HOUR OF DEATH June 9, 1967 9:18 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 40 Saint Agnes Hospital Caton & Wilkens Ave. 21229		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) Apt. 23 Oaklee Village			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/18/88	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard Darby		14. MOTHER'S MAIDEN NAME Laura - - -	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mr. Oswald B. Spellman, Sr. 23 Oaklee Village 21229	
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH ASCVD (A) DUE TO (B) DUE TO Essential Hypertension ? (C) _____		INTERVAL BETWEEN ONSET AND DEATH ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-12 19 65 to 5-76 19 67 , that (I) (he) last saw the deceased alive on 5-76 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Earl Pass				23B. DATE SIGNED 6-9-67	
23C. PHYSICIAN'S NAME (Type) I. Earl Pass		23D. ADDRESS 4001 Wilkens Ave., Balto., Md. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/67		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard F.H. 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>67 5661</u>	
BIRTH NO. <u>67 5661</u>										M.E. CASE NO. <u>67 10823</u>	
1. NAME OF DECEASED (Type or Print) <u>Baby Girl DAVIS</u>					2. DATE AND HOUR OF DEATH <u>6/7/67</u> <u>5:01 P.M.</u>						
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>						
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Johns Hopkins Hosp.</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>						
D. STREET ADDRESS (If rural, give location) <u>1035 Aisgwith ST.</u>											
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>never married</u>	8. DATE OF BIRTH <u>6/3/67</u>	9. AGE (In years lost birthday) <u>4 days</u>	10. Under 1 Yr. Months Days Hours Min.		11. Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>UNKNOWN</u>					14. MOTHER'S MAIDEN NAME <u>BARBARA DAVIS</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT ADDRESS						
18. <u>774X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARDIAC ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Respiratory Arrest</u> <u>Prematurity</u>					INTERVAL BETWEEN ONSET AND DEATH						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>None</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>None</u>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>6/3</u> <u>19 67</u> to <u>6/7</u> <u>19 67</u> that (I) (we) last saw the deceased alive on <u>6/7</u> <u>19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>James B. Brayton</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/7/67</u>				
23C. PHYSICIAN'S NAME (Type) <u>James B. BRAYTON</u>					23D. ADDRESS <u>The Johns Hopkins Hospital</u>						
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>			24B. DATE <u>6-8-67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>JOHNS HOPKINS HOSPITAL</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>				
25A. DATE RECEIVED BY HEALTH DEPT. <u>JUN 12 1967</u>			25B. NAME OF REGISTRAR <u>Robert E. Gentry</u>			25C. FUNERAL DIRECTOR ADDRESS <u>HOSPITAL DISPOSAL</u>					

GRANDSON (B-2) JOHN HOBBS HOBBS, BALTIMORE, MD

JAMES B BRAYTON
JAMES B. BRAYTON

at Johns Hopkins Hosp in

6/13 67

now
no
now

Presbyterian
Respiratory Assoc
Catholic Assoc

NO
n/a

Unknown
n/a

never married 6/13/67 +
BALTIMORE MD
n/a
f

1032 First with St.

Baltimore

Married 6/13/67

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>Balto Co. Md</i> 67 5662		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5662	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) SAMUEL T. CHENWORTH III			2. DATE AND HOUR OF DEATH 6-8-67 2.15 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND B. COUNTY BALTIMORE Co.		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00		
			D. STREET ADDRESS (If rural, give location) 18 HELICOPTER DRIVE 21220		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 3-5-67	9. AGE (In years lost birthday) 3 3	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SAMUEL CHENWORTH JR		14. MOTHER'S MAIDEN NAME THERESA SHULER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT SAM CHENWORTH JR	
18. 75 4.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Venous Anomalous Drainage		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Congenital heart disease			
(B) DUE TO		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6-7-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Anomalous pulmonary drainage		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-19 1967 to 6-8 1967 , that (I) (we) last saw the deceased alive on 6-8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L.C. Parks MD				23B. DATE SIGNED 6-8-67	
23C. PHYSICIAN'S NAME (Type) Leon C Parks				23D. ADDRESS M.D. Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/9/67		24C. NAME OF CEMETERY or CREMATORY ST FRANCIS	
24D. LOCATION Baltimore, Md		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. [illegible]		25C. FUNERAL DIRECTOR J. E. CONNELLY SONS	
25D. ADDRESS 300 MACE					

Account of the
Society of Friends
in the Year 1847

1847

1847

John C. Parker
1847

John Parker
1847

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5663		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5663	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Albert Washington Burnham</i>			2. DATE AND HOUR OF DEATH <i>6/6 1967 4:10 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Brooklandville</i>		
			D. STREET ADDRESS (If rural, give location) <i>Valley Rd</i>		
5. SEX <i>Male</i>	6. RACE <i>Caucasian</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>5/3/86</i>	9. AGE (In years last birthday) <i>81</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Horticulture</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>E. Lyaha Burnham</i>		
14. MOTHER'S MAIDEN NAME <i>Mary Ann Lee</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <i>220-30-2621</i>			17. INFORMANT <i>Mrs. John M. Doyle</i>		
18. <i>331X1</i>			ADDRESS <i>Box 315 Greenway Rd. Cockeysville</i>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <i>Cerebrovascular Accident</i> <i>9 days</i>		
			(B) <i>B</i>		
			(C) <i>Bronchopneumonia</i> <i>6 days</i>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				<i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/23</i> 19 <i>67</i> to <i>6/6</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6/6</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nat E. Watson</i>				23B. DATE SIGNED <i>6/6/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>NAT E. WATSON, JR.</i>				23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6/9/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Saters Baptist Church</i>	
				24D. LOCATION (City, town, or county) (State) <i>Lutherville Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 12 1967</i>		25B. NAME OF REGISTRAR <i>John E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>John Burns Sons</i>	
				ADDRESS <i>10 W 5th</i>	

Chief Washington Reservation

6/6

1917

RD

Brooklandville

Valley Rd

81

2/2/20

Green Memorial Hospital

Male Cancer Widowed

Gardener Horticulture Maryland

Eliza Burman

John W. Lee

John W. Lee

Cerebral Vascular Accident

Branchiopneumonia

No

2/2/20

2/2/20

6/6

Mark. Watson

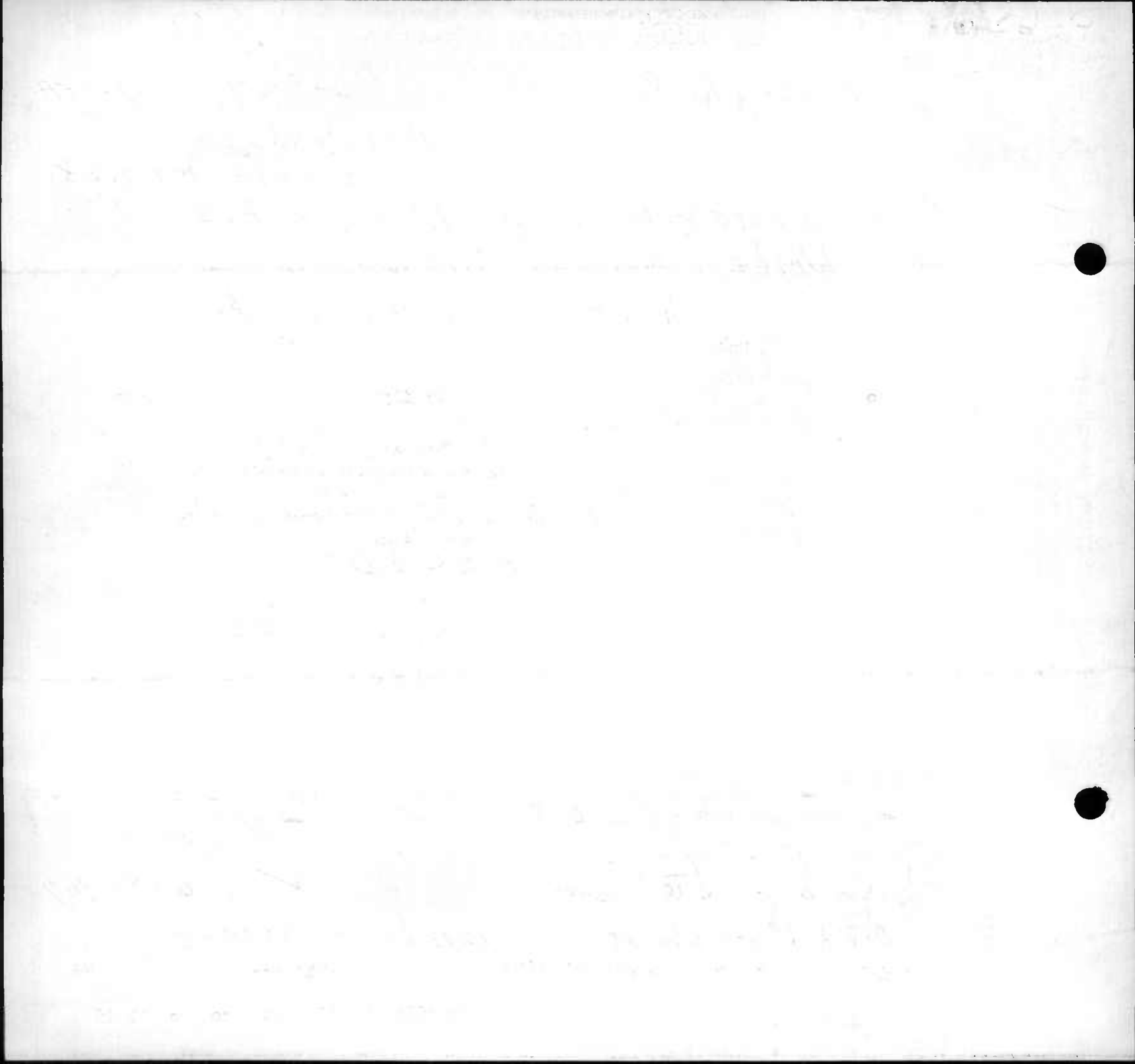
1917

1917

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

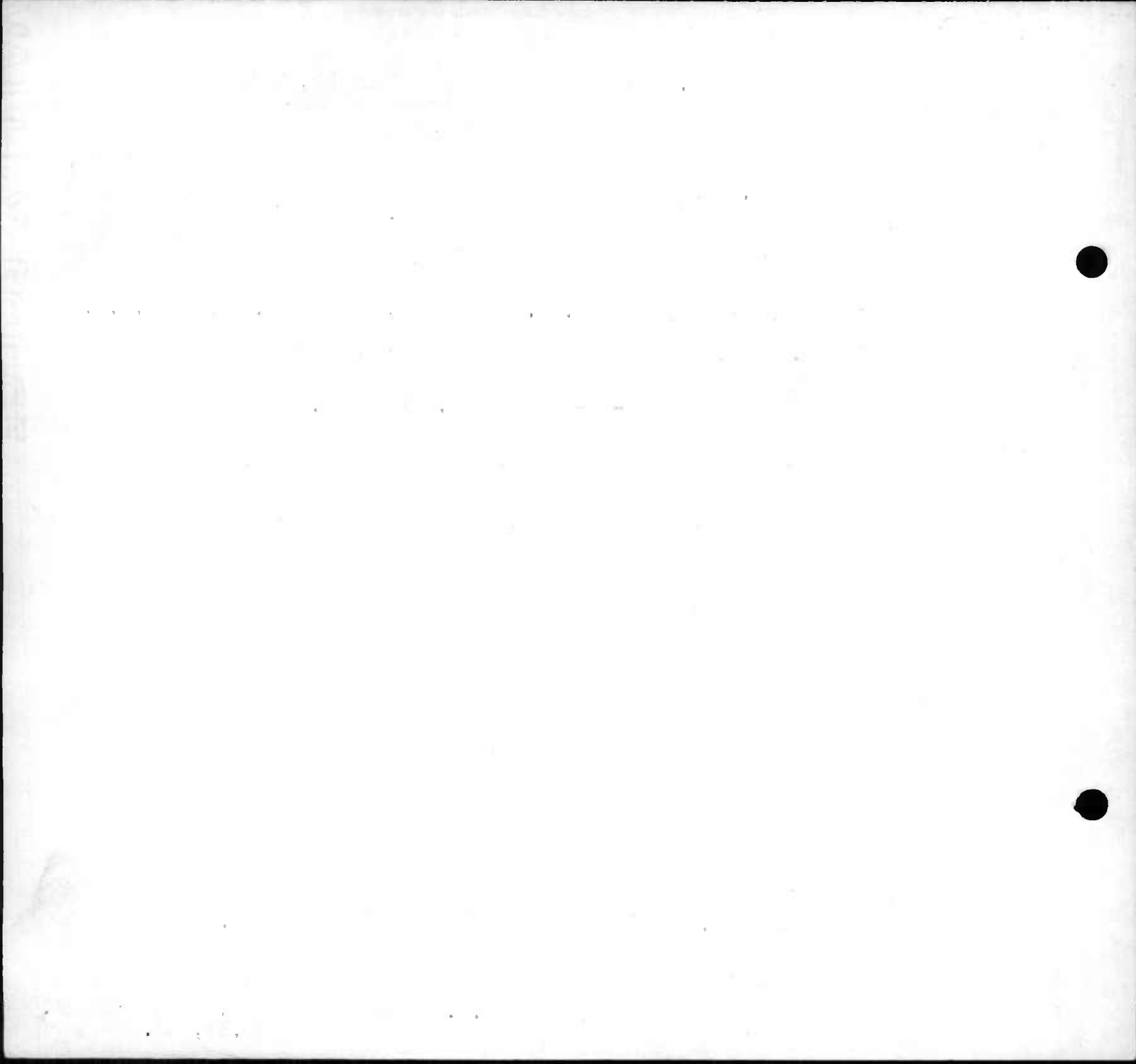
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5664	
BIRTH NO. 67 5664		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Dorothy M. Parks.</i>		2. DATE AND HOUR OF DEATH <i>6-8-67 12:05 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>A.A.C.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21225</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp.</i>		D. STREET ADDRESS (If rural, give location) <i>117 Davis Ave. 52-00</i>			
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>7/19/1895</i>	9. AGE (In years last birthday) <i>71</i>	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
13. FATHER'S NAME <i>Unk</i>		14. MOTHER'S MAIDEN NAME <i>Unk</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i>	
18. <i>451X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Renal Failure due to Renal Artery Shutdown</i>		CAUSE OF DEATH (A) DUE TO <i>Dissecting abdominal aortic aneurysm</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <i>ASCD</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>ASHD = chronic CHF.</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <i>6-5</i> 19 <i>67</i> to <i>6-8</i> 19 <i>67</i> , that we (we) last saw the deceased alive on <i>6-8</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David J. Steinbauer</i> M.D.				23B. DATE SIGNED <i>6-8-1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>David J. Steinbauer</i>		23D. ADDRESS <i>1213 Light Street</i> M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/12/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Garden of Faith</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. STATE <i>Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 12 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>McCully F H</i>	
25D. ADDRESS <i>237 Patapsco Ave</i>		25E. CITY <i>21225</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 67 5665	
BIRTH NO. 67 5665		CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LeRoy G. Patton				2. DATE AND HOUR OF DEATH June 11, 1967 8 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 619 St. Dunstan's Road				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 619 St. Dunstan's Road			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 7/12/1896	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Claims Supervisor Ins.Co.				10B. KIND OF BUSINESS OR INDUSTRY Monumental Life		11. BIRTHPLACE (State or foreign country) Rocks, Harford Co Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William R. Patton				14. MOTHER'S MAIDEN NAME Bertha Streett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 213-03-3678A		17. INFORMANT Mrs. Mildred E. Patton		ADDRESS (Same)	
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 163 X I Generalized carcinomatosis carcinoma of lung				INTERVAL BETWEEN ONSET AND DEATH 1 year r/1/2 years			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? If in Baltimore City, give exact location			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 3, 1967 to June 11, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William B. Settle				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 12, 1967	
23C. PHYSICIAN'S NAME (Type) William B. Settle				23D. ADDRESS 508 Medical Arts Bldg.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/13/1967		24C. NAME OF CEMETERY or CREMATORY Greenmount		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robt. E. Taylor		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5666</u>	
BIRTH NO. <u>67 5666</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>WUSTLAND, URITH G.</u>		2. DATE AND HOUR OF DEATH <u>Jun 10, 1967</u> <u>1125</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPT.</u>		D. STREET ADDRESS (If rural, give location) <u>3309 BEVERLY ROAD</u>		E. ZIP CODE <u>21201</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>03-10-85</u>	9. AGE (In years last birthday) <u>82</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>GEORGE W. HARGEST</u>		14. MOTHER'S MAIDEN NAME <u>ELLA FAUST</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-52-4102</u>		17. INFORMANT <u>EDITH Mrs. Schultze (daughter) (SAME)</u>	
18. <u>331X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cerebro-Vascular Accident 32 days</u> (B) <u>Generalized Arterio-Sclerosis</u> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>May 19 1967</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>May 19 1967</u> to <u>Jun 10 1967</u> and that (we) last saw the deceased alive on <u>Jun 10 1967</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Giselle T. Bretz</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Jun 10, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>GISELLE T. BRETZ</u>		23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>		M.D. <u>Union Memorial Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/13/1967</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>	
24D. LOCATION <u>Baltimore</u>		24E. STATE <u>Md.</u>		24F. ADDRESS <u>Baltimore</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>JUN 12 1967</u>		25B. NAME OF REGISTRAR <u>H. W. Jenkins & Sons Co.</u>		25C. FUNERAL DIRECTOR <u>4905 York Rd. Balto. 12, Md.</u>	

3309 BEVERLY ROAD
BALTIMORE
MONTGOMERY
03-10-82

GEORGE W. HARDEST
NORTH
WISCONSIN

Generalissimo
Central Intelligence Agency
Mr. Schultz

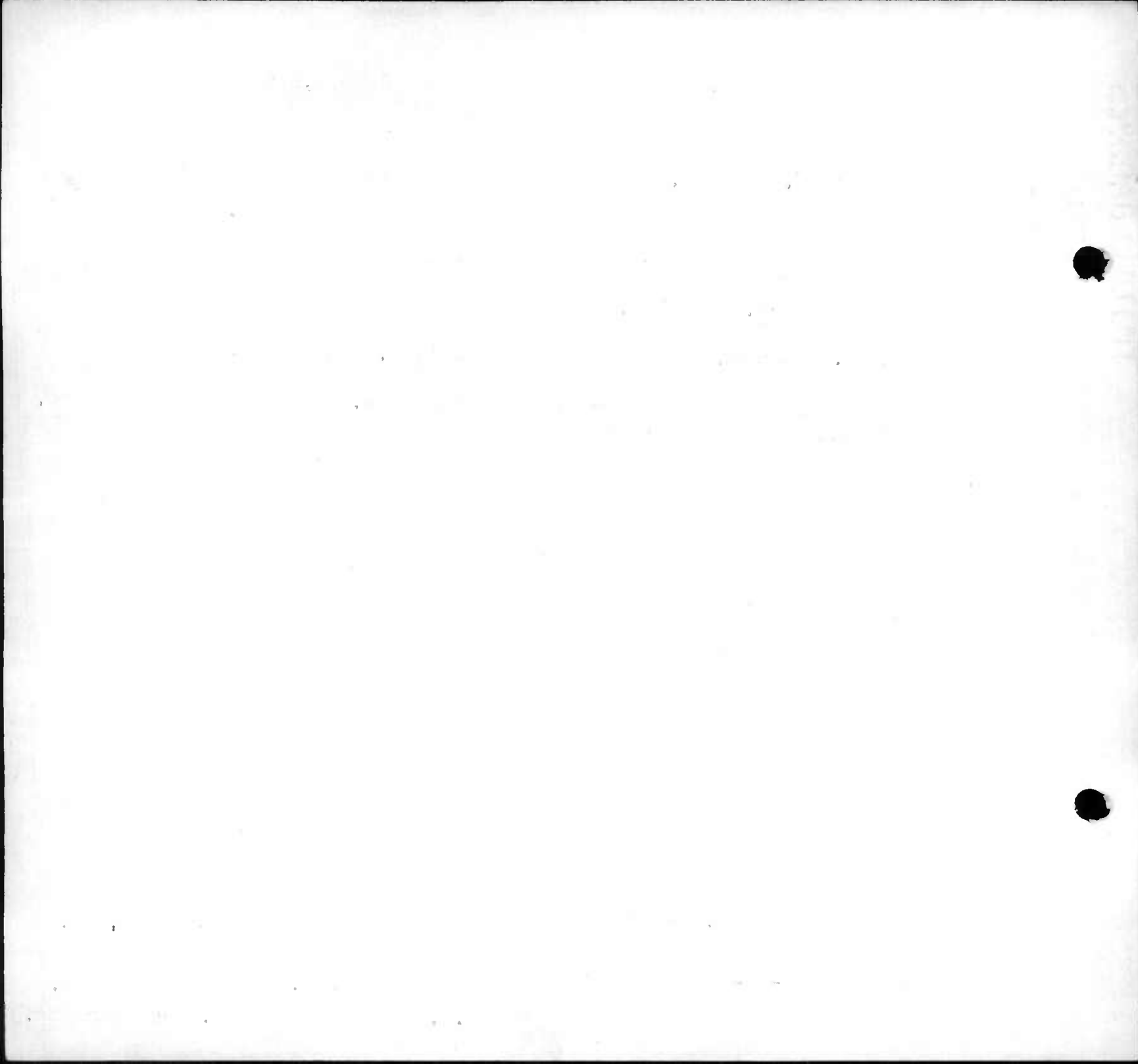
NO
JAN 10 1982
JAN 10 1982

George W. Hardest
JAN 10 1982

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 5667 CERTIFICATE OF DEATH					Registered No. 67 5667					
BIRTH NO.					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH					
FRANK J. PLUNKETT					June 9, 1967 6:30 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY					
614 E. 29th St.					Maryland					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
					Baltimore					
					D. STREET ADDRESS (If rural, give location)					
					705 Benninghaus Rd.					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
M	W	Widowed	10-9-1905	61	Policeman (Ret.)	Balto. City	Maryland	USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Frank J. Plunkett					Annie C. Fitzsimmons					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No					215-07-1449		William J. Plunkett 3738 Beech Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) <i>Arterio Sclerosis</i> DUE TO <i>Cardiac Failure</i>					<i>Probably 3 yr</i> <i>6 weeks</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>April 28</i> 19 <i>67</i> to <i>June 9</i> 19 <i>67</i> . that (I) (we) last saw the deceased alive on <i>June 5</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Milton B. Kress</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>6/12/67</i>		
23C. PHYSICIAN'S NAME (Type) Milton B. Kress					23D. ADDRESS Medical Arts Building, Balto., Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)		
Burial		6-13-67		New Cathedral		Balto.		Md.		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS				
JUN 12 1967		<i>Robert E. Taylor</i>		H.W. Jenkins & Sons Co.		4905 York Rd.				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burial; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 5668

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 5668

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Watkins, Leonard R.

2. DATE AND HOUR OF DEATH

June 11-67 11:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD 3700 N. Charles St

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore M 1201

D. STREET ADDRESS (If rural, give location)

see above

5. SEX

♂ m

6. RACE

W

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

11-04-95 71

9. AGE (In years
last birthday)

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Vehicle Exec. Printing

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILBUR WATKINS

14. MOTHER'S MAIDEN NAME

ELLA ROBINSON

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW I

16. SOCIAL
SECURITY NO.

059-09-8840

17. INFORMANT

MRS. EDITH F. WATKINS

ADDRESS (SAME)

18.

420.1 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Asystole due to Myocardial Infarction

(B) arteriosclerotic C.V.D. 2.

(C) (Thrombosis of popl. artery)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Popliteal aneurysm.

19A. DATE OF OPERATION

6-10-67

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Popliteal aneurysm

20A. AUTOPSY (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☒

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 10 1967 to June 11 1967,
that (I) (we) last saw the deceased alive on June 11 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Albert C. W. Montague

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)ALBERT C. W. MONTAGUE,
MONTAGUE

M.D.

23D. ADDRESS

MEDICAL ARTS BUILDING
BALTIMORE, MARYLAND 2120224A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/14/1967

24C. NAME OF CEMETERY or CREMATORY

Druid Ridge

24D. LOCATION

(City, town, or county)

(State)

Pikesville, Balto. Co., Md.

25A. DATE RECEIVED BY HEALTH DEPT.

JUN 12 1967

25B. NAME OF REGISTRAR

Phyllis E. Taylor

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.

ADDRESS

5677 Balto. 12, Md.

WILBUR WATKINS
 1234 Main St.
 Springfield, Mass.
 11-07-71
 Yes W W I
 029-02-240 MRS. E. WATKINS
 (240)

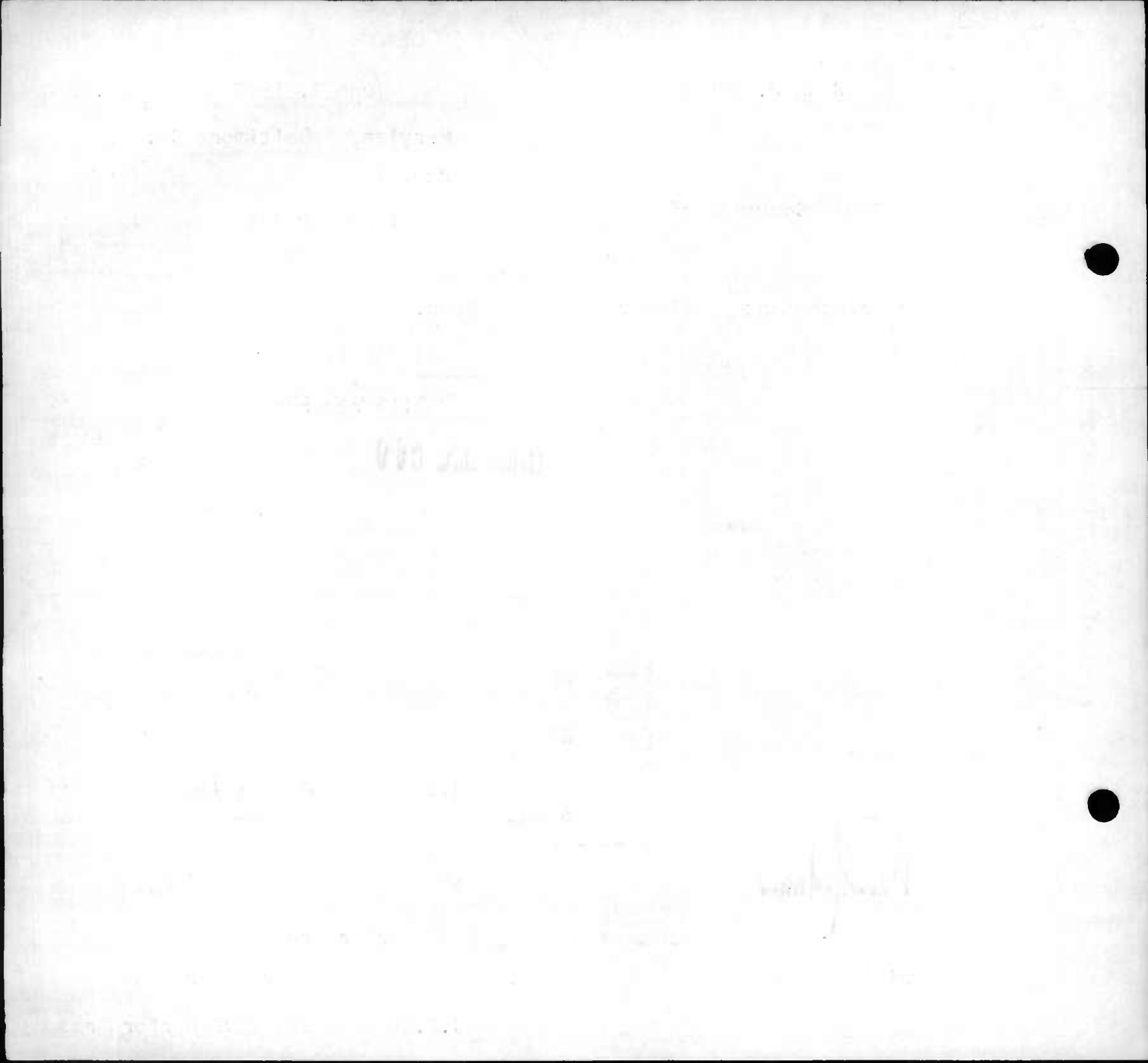
The number of copy sent
 out for the (10)
 11-07-71
 Published answer
 No

MONTAGNE
 11-07-71
 11-07-71
 11-07-71

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5669	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 5669 X </div>					
<div style="display: flex; justify-content: space-between;"> M.E. CASE NO. CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) JOHN J. HUGHES			2. DATE AND HOUR OF DEATH June 7, 1967 10.30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Gould Convelasarium			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Parkville 53-00 D. STREET ADDRESS (If rural, give location) 8803 Wilson avenue		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH Feb 26 1897	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendant		10B. KIND OF BUSINESS OR INDUSTRY Fisher Body		11. BIRTHPLACE (State or foreign country) Penn.	
13. FATHER'S NAME John S Hughes			14. MOTHER'S MAIDEN NAME Anna Kelly		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-5411		17. INFORMANT ADDRESS Family records	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerosis CVD			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH 2 yr		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 20 July 1965 to 6 June 1967 , that (I) (we) last saw the deceased alive on 6 June 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 9 June 67	
23C. PHYSICIAN'S NAME (Type) Howard Goodman MD.				23D. ADDRESS 8604 Harford road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-10-67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR JUN 12 1967		25C. FUNERAL DIRECTOR ADDRESS J. C. F. EVANS & SON 8802 Harford road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5670	
BIRTH NO. 67 5670				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) JAMES PANUSKA			2. DATE AND HOUR OF DEATH June 9, 1967 12:15 p. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 410 N. Collington Ave. 00 Baltimore, Md. 21231			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 410 N. Collington Ave.		
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 7/11/92	9. AGE (In years last birthday) 74	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY U.S. Govt. Post Office		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Charles Panuska			14. MOTHER'S MAIDEN NAME Caroline Zoubek		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W.1 - Army		16. SOCIAL SECURITY NO. 215-03-1275		17. INFORMANT ADDRESS Frances Ruzek Panuska, wife, above	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Pulmonary edema DUE TO (B) Cardiac de compensation DUE TO (C) Carcinoma prostate metastases to bones		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1966 to June 9 1967, that (I) (we) last saw the deceased alive on June 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.					
23A. SIGNATURE Charles MacMinn M.D.			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) Dr. Charles MacMinn M.D.			23D. ADDRESS 2900 E. Baltimore St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/67		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 12 1967		25B. NAME OF REGISTRAR Robert E. Salsburg		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601 E. Madison St.	

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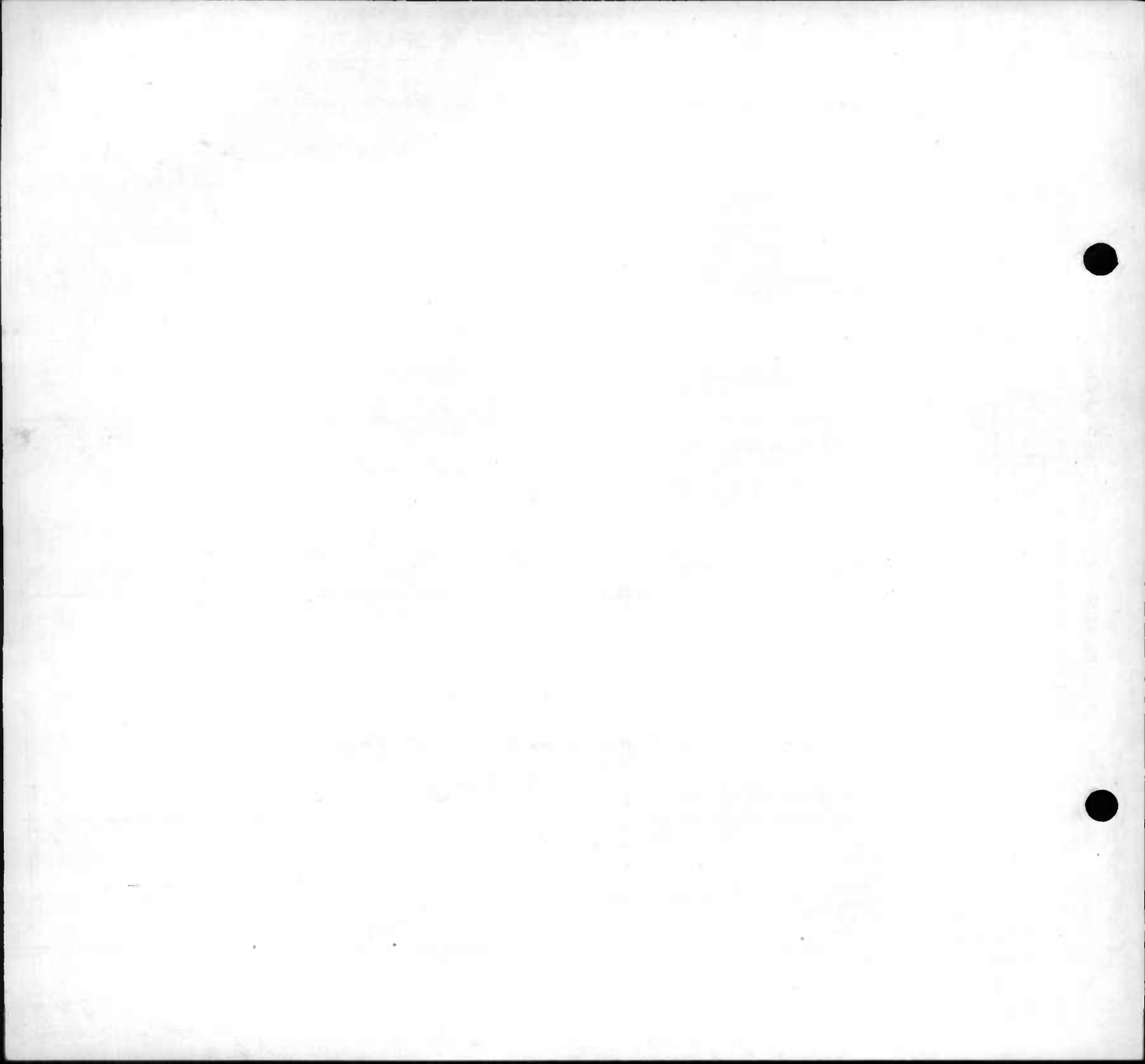
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5671				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5671	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Beatrice Mack</i>			
2. DATE AND HOUR OF DEATH <i>June 5th 1967 11⁴⁰ P. M.</i>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>3324 Canton Ave.</i>				A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>20-07</i> D. STREET ADDRESS (If rural, give location) <i>3324 Canton Ave.</i>			
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Feb. 1, 1901</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Laurelton, Va.</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>Fredrick S. W. Lee</i>				14. MOTHER'S MAIDEN NAME <i>E. Pinn</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Leon Lee</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>443X1</i>				CAUSE OF DEATH (A) DUE TO <i>Cardiac failure</i> (B) DUE TO <i>Hypertensive type H.25</i> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5/30</i> 19 <i>67</i> to <i>6/5</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Evan A. Gilkes</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6-12-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Evan A. Gilkes</i>				23D. ADDRESS M.D. <i>3033 W. North Ave.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-8-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Man. Park</i>		24D. LOCATION (City, town, or county) (State) <i>Arbutus Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 12 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Elmer S. Wilson</i>		ADDRESS <i>1000 Rmthly Ave.</i>	



Almedio
52-74-39
FUNERAL DIRECTOR: IMPORTANT
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5672				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5672	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Pedro Almedio</i>				2. DATE AND HOUR OF DEATH <i>6/10/67</i> <i>3:10</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>33 THE JOHNS HOPKINS HOSPITAL</i>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>1644 ABBOTT STREET 21205</i>			
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>3-1-96</i>	9. AGE (In years last birthday) <i>71</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Blind</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Portuguese</i>		12. CITIZEN OF WHAT COUNTRY? <i>White</i>	
13. FATHER'S NAME <i>ANTONIO PORTIGAL</i>				14. MOTHER'S MAIDEN NAME <i>MARIA SORES</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mary Smith</i>		ADDRESS	
18. <i>177X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Metastatic Ca of Prostate</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Metastatic Ca of Prostate</i> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <i>6/10 1967</i> to <i>6/10 1967</i> , that (we) last saw the deceased alive on <i>6/10 1967</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.							
23A. SIGNATURE <i>M. Katz</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6/10/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>M. KATZ</i>				23D. ADDRESS M.D. <i>THE JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-13-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>mt Arden Cmt</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
25A. DATE RECEIVED BY HEALTH DEPT. <i>JUN 12 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Alfred Wilson 1001 Bryant Ave</i>		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 5673		67 5673	
BIRTH NO.				67 5673		Registered No.	
M.E. CASE NO.				67 5673		P.M.	
1. NAME OF DECEASED (Type or Print) Beri Coley				2. DATE AND HOUR OF DEATH June 10 1967		2:30	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bolton Hill Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1933 E Chase Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-15-88	9. AGE (In years last birthday) 78	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Coley			14. MOTHER'S MAIDEN NAME Cornelia Armstrong				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT Maggie Coley		ADDRESS Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 177 X + 260 X (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cancer of the Prostate Gland				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. Ellsworth Cook				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-10-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6-13-67		24C. NAME of CEMETERY or CREMATORY Int. Antuan Ant		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D JUN 12 1967		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Ernest O. Wilson		ADDRESS 1000 Brantley Ave.	

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5674		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5674	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Ella Gray</i>		2. DATE AND HOUR OF DEATH <i>June 5-1967 10:30 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>X</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>001575 Bruce St.</i>		D. STREET ADDRESS (If rural, give location) <i>208 N. Hemont Ave</i>		18-01	
5. SEX <i>Female</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>Sept. 12, 1893</i>	9. AGE (In years last birthday) <i>74</i>	10. If Under 1 Yr. Months; Days; Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
12. CITIZEN OF WHAT COUNTRY <i>USA</i>		13. FATHER'S NAME <i>Henry Gray</i>		14. MOTHER'S MAIDEN NAME <i>Louise ?</i>	
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>James</i>	
18. 334 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cardiac degeneration</i> (B) <i>Cerebral arteriosclerosis</i> <i>Malnutrition</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> <i>1965</i> <i>1965</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>1965</i> 19 to <i>1967</i> 19, that (I) (we) last saw the deceased alive on <i>June 5</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>GEO. H. PENDLETON</i>	
23B. DATE SIGNED <i>6-12-67</i>		23C. PHYSICIAN'S NAME (Type) <i>GEO. H. PENDLETON</i>		23D. ADDRESS <i>1723 Lind Hall Ave</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-12-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Calvary</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		25A. DATE RECEIVED <i>JUN 10 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Schley</i>	
25C. FUNERAL DIRECTOR <i>Shoykhan 1000 Cranberry St</i>		25D. ADDRESS			

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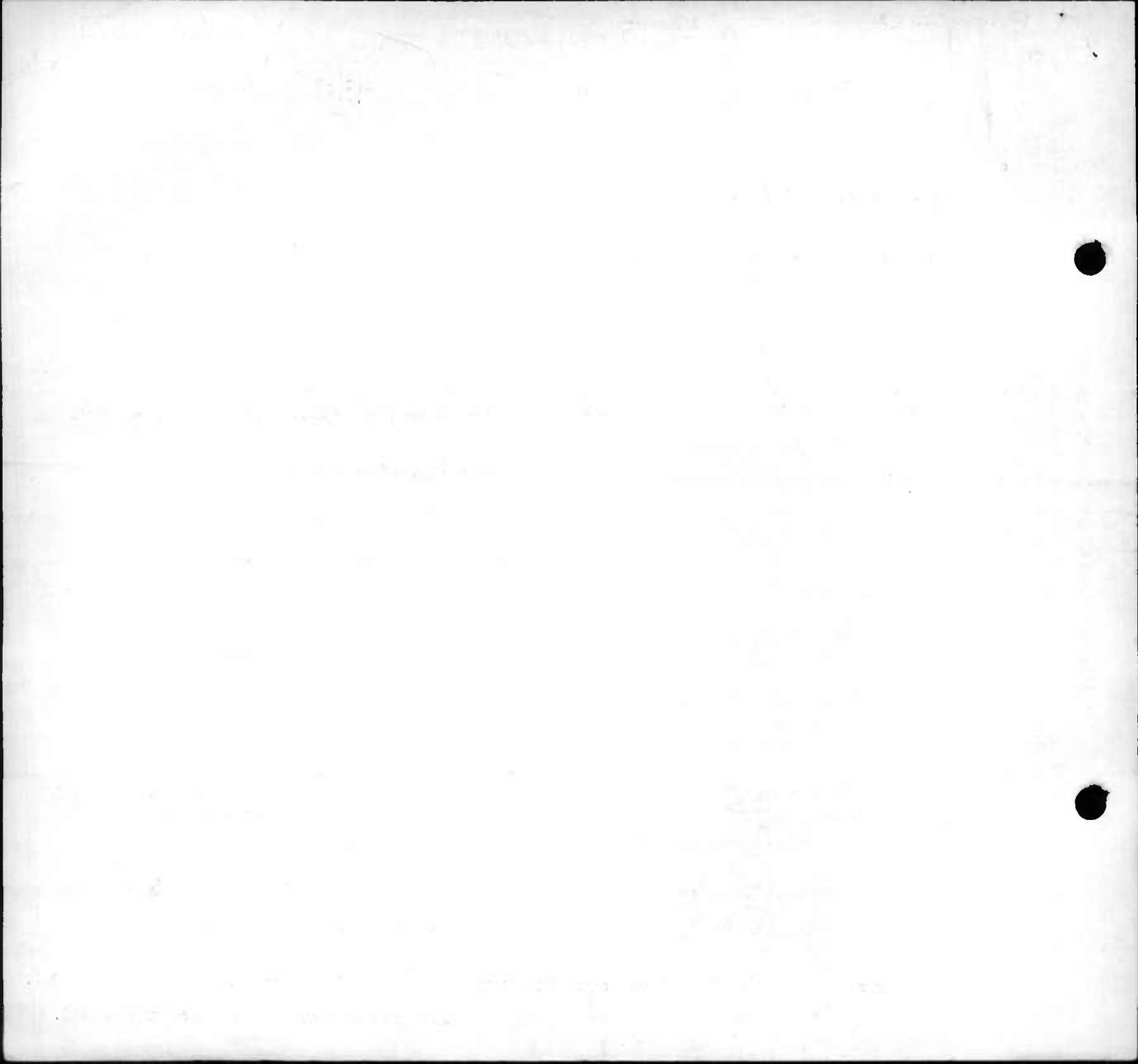
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

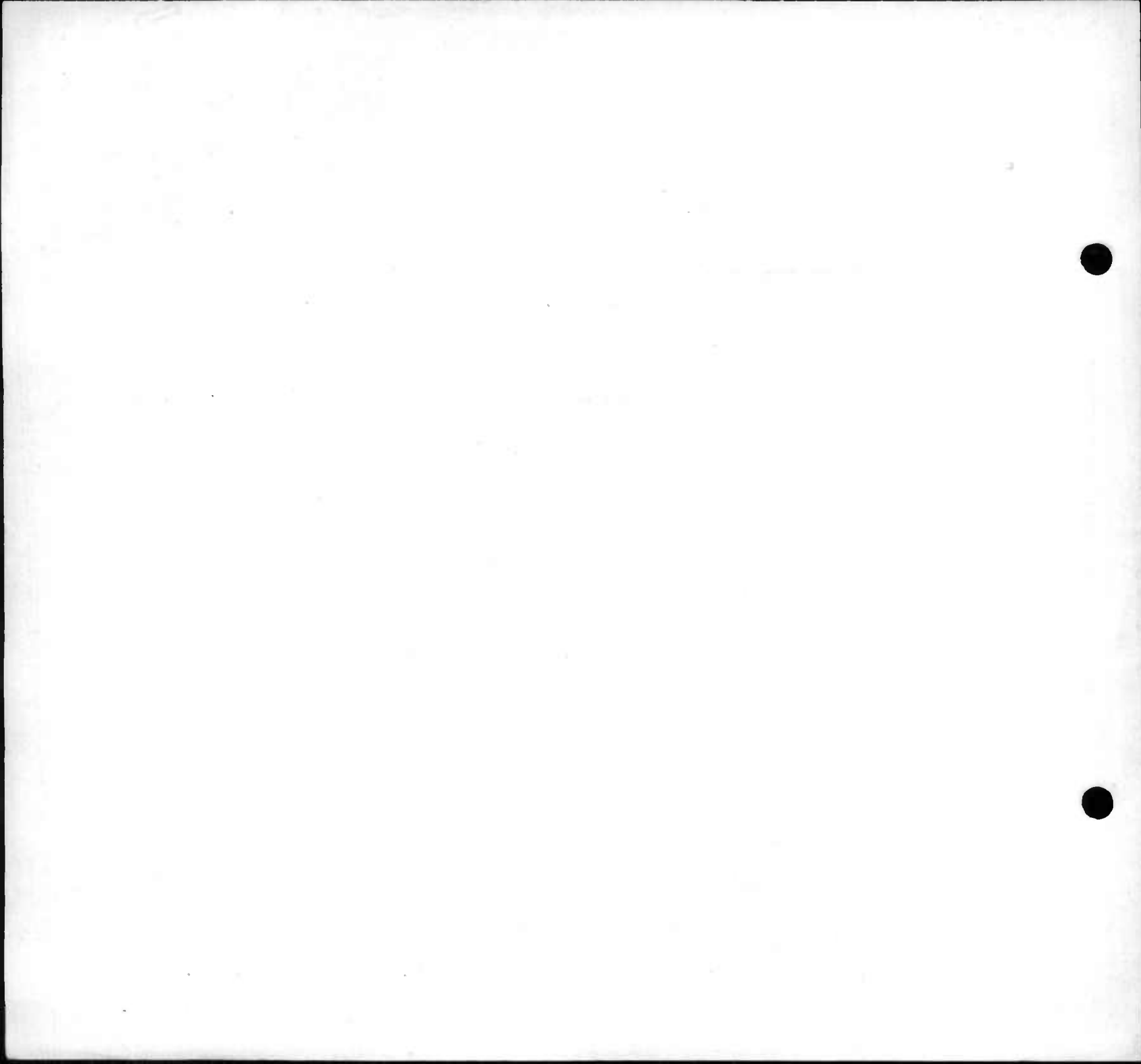
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5675	
BIRTH NO. 67 5675		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BROOKS, PHILLIPS MELVIN			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH 6/8/67 11:5 AM M.			
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Dorchester Co.			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) CAMBRIDGE			
		D. STREET ADDRESS (If rural, give location) 608 WILLIS ST.			
5. SEX MALE	6. RACE CAUCASIAN	7. <input checked="" type="checkbox"/> MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (specify)	8. DATE OF BIRTH 6/11/01	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME J. W. BROOKS		14. MOTHER'S MAIDEN NAME NICEY A. NIELD		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT MR. Clayton Brooks, Cambridge, MD	
18. 00341		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) CARDIAC ARREST			
ANTECEDENT CAUSES		(B) PROBABLE SEPSIS			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from JUNE 5 19 67 to JUNE 7 19 67 , that (I) <u>(we)</u> last saw the deceased alive on JUNE 7 19 67 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE William H. Barker, Jr.				23B. DATE SIGNED 6/8/67	
23C. PHYSICIAN'S NAME (Type) WILLIAM H. BARKER, JR.				23D. ADDRESS UNIV. MD. HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/9/67		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel County Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR Robert E. Fairley, Jr.		25C. FUNERAL DIRECTOR LeCompte Funeral Home	
				ADDRESS Cambridge, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5676 CERTIFICATE OF DEATH					Registered No. 67 5676				
BIRTH NO. M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)				
WILLIAM ELMER SIPES					2. DATE AND HOUR OF DEATH June 9, 1967 14:00 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived; If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE Md.				
3209 Kenyon Ave. Baltimore, Md. 21213					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
D. STREET ADDRESS (If rural, give location)					3209 Kenyon Ave.				
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 11/27/03	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Checker			10B. KIND OF BUSINESS OR INDUSTRY Red Line, Inc.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Sipes					14. MOTHER'S MAIDEN NAME Elsie Matthias				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 215-09-0272		17. INFORMANT Evelyn Brown Sipes, wife, above				
18. 332 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Cerebral Thrombosis DUE TO (B) Cerebral Arteriosclerosis DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH Immediate 5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 9 1962 to June 9 1967, that (I) (we) last saw the deceased alive on April 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Melvin F. Pohrek					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 6-10-67	
23C. PHYSICIAN'S NAME (Type) MELVIN F. POHREK					23D. ADDRESS M.D. 3603 BELAIR ROAD BALTO. MD				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/112/67		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem.			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967			25B. NAME OF REGISTRAR R. B. E. F. F. F.			25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 33331 Brehms Lane			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

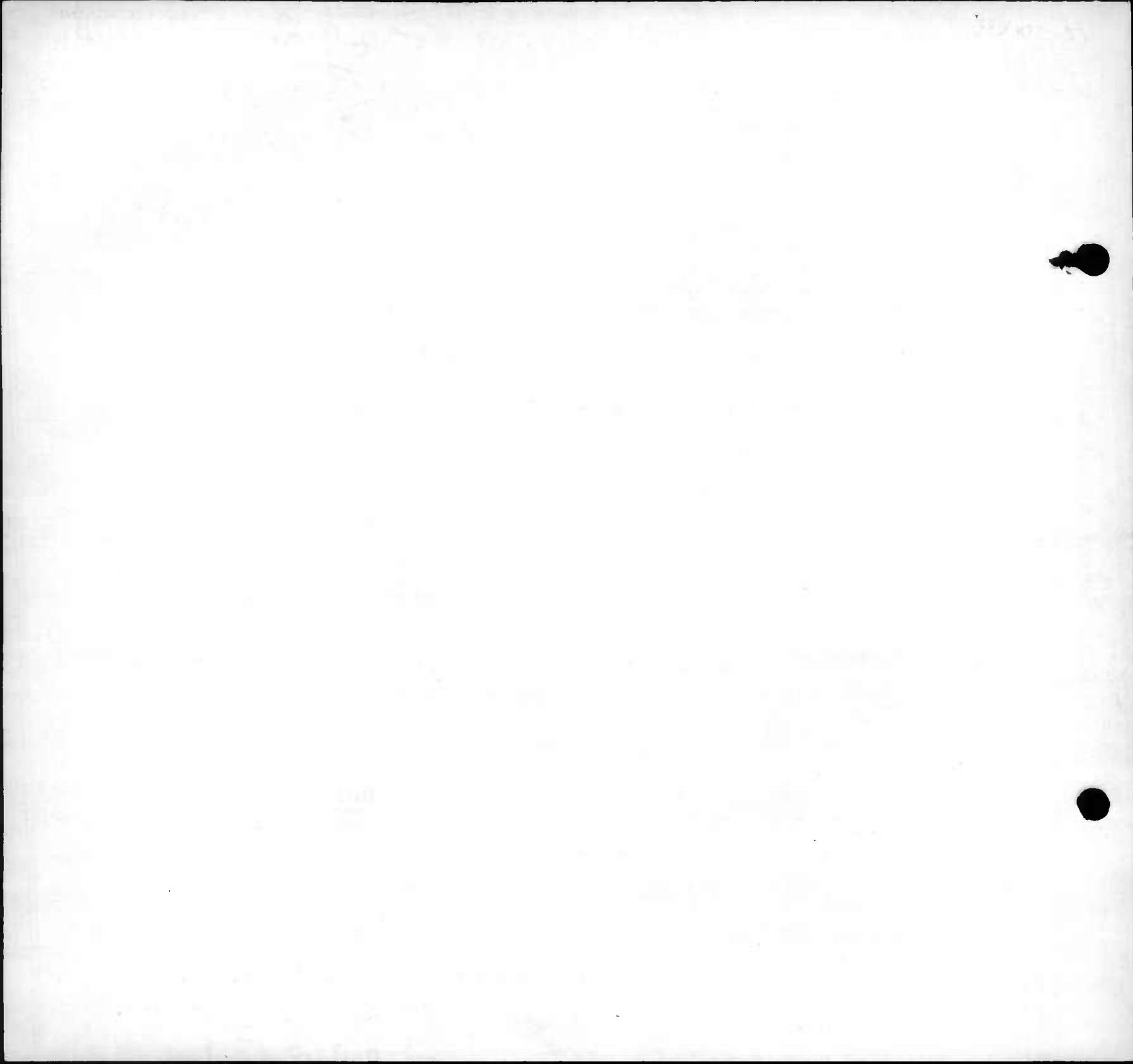
BALTIMORE CITY HEALTH DEPARTMENT				67 5677	
BIRTH NO.				67 5677	
M.E. CASE NO.				Registered No.	
1. NAME OF DECEASED (Type or Print) JOHN A. KLIMA			2. DATE AND HOUR OF DEATH 6-10-67 9⁰⁰ A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 33RD & CALVERT ST. UNION MEM. HOSP.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALT C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) 606 STUART ST		
5. SEX M	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 1-27-1891	9. AGE (In years lost birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS DRIVER (RET.)		10B. KIND OF BUSINESS OR INDUSTRY BALTO. TRANSIT		11. BIRTHPLACE (State or foreign country) NEW YORK	
13. FATHER'S NAME VINCENT KLIMA			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 216-094569		17. INFORMANT ADDRESS WALTER KLIMA 606 STUART ST. #21
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION - POST - LATERAL LEFT MYOCARDIUM			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CIRRHOSIS OF LIVER					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. BRONCHO PNEUMONIA					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-9 1967 to 6-10 1967, that (I) (we) last saw the deceased alive on 6-10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert P. Doyle M.D.				23B. DATE SIGNED 6/10/67	
23C. PHYSICIAN'S NAME (Type) ROBERT P. DOYLE				23D. ADDRESS M.D. UNION MEMORIAL HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/67		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR Robert P. Doyle		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	

John D. Ketchum

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

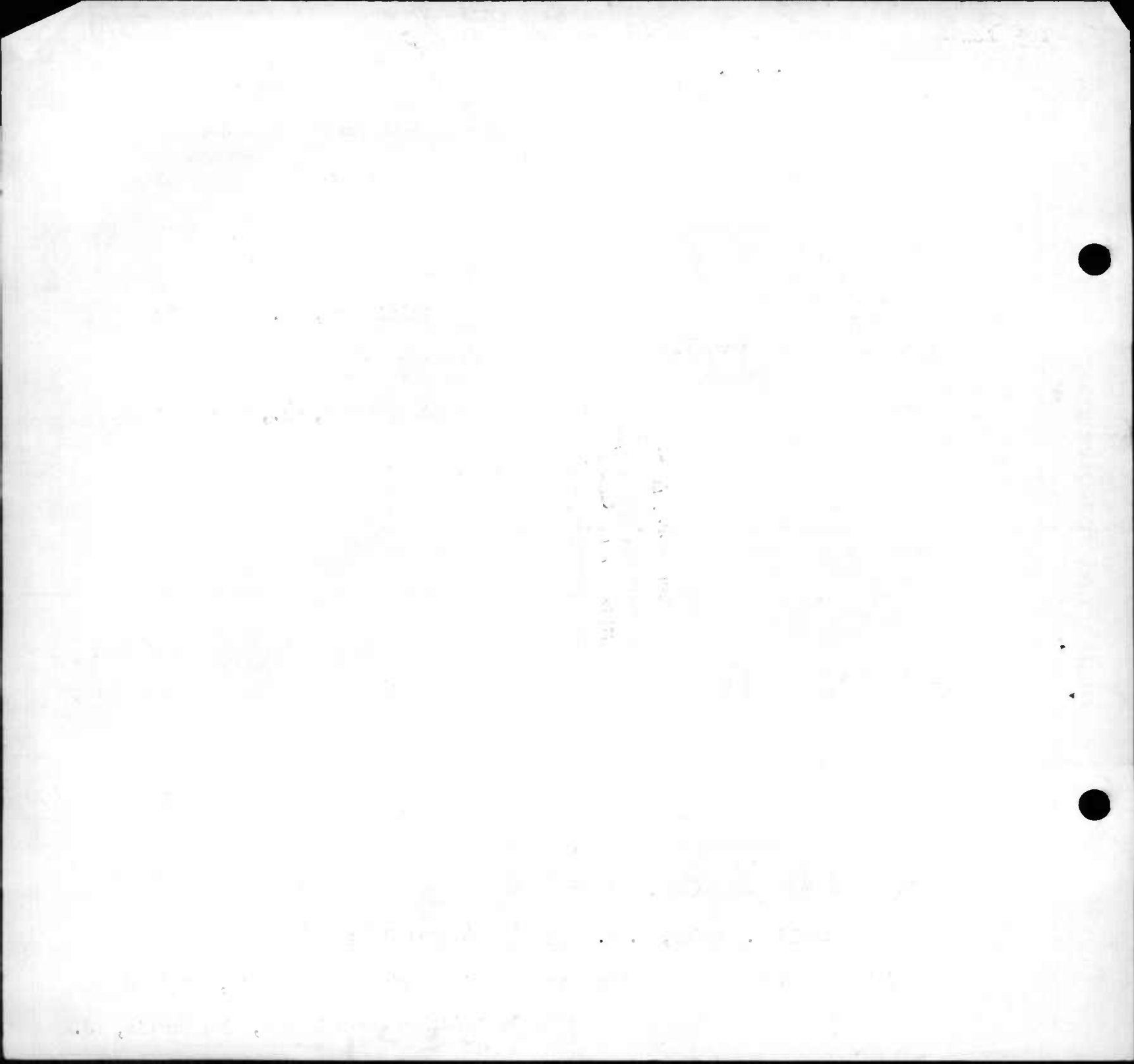
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5678	
BIRTH NO. 67 5678		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CHARLES MORRISON HARE			
2. DATE AND HOUR OF DEATH 11 JUNE 67 8:00 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND UNIVERSITY OF MARYLAND HOSP. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE COY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1031 EASTERN AVENUE APT. C.			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-15-96	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Tavern		10B. KIND OF BUSINESS OR INDUSTRY Own Business		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GRANT HARE			
14. MOTHER'S MAIDEN NAME Annie Jones		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN WW1- Army			
16. SOCIAL SECURITY NO. 217-03-9913		17. INFORMANT P's CHART			
18. 162.1 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) CARCINOMA OF THE LUNG - CAT CEL DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) POSSIBLE AMPULLARY CARCINOMA DUE TO OR METASTASIS			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11 June 1967 to same date 1967 , that (I) (we) last saw the deceased alive on 11 June 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sidney Stapleton Jr		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11 June 67	
23C. PHYSICIAN'S NAME (Type) SIDNEY STAPLETON, JR		23D. ADDRESS M.D. UNIVERSITY OF MARYLAND HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/15/67	24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR Robert E. Fabela		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. ADDRESS 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5679	
BIRTH NO. 65-08797		67 5679		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SPONSER, Brooks		2. DATE AND HOUR OF DEATH 2:45 AM 6-9-67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hospital		A. STATE MARYLAND B. COUNTY ANNE ARUNDEL			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Ferndale, Md. 52-00			
D. STREET ADDRESS (If rural, give location) 204 PACKARD AVE.					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 4/15/65	9. AGE (In years last birthday) 2 YEARS	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert Sponser, Jr.		14. MOTHER'S MAIDEN NAME Beverly Sylvius	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Robert Sponser, Jr., Same as 1	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Burn - 70%		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
19A. DATE OF OPERATION 6-7-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pulm Atelectasis		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 304 Packard Ave Ferndale		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 5 26 67 10:30	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? child playing with matches in basement playroom or party room			
22. I certify that (I) (this hospital) attended the deceased from 5-26 19 67 to 6-8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald D. Snyder, M.D.				23B. DATE SIGNED 6-8-67	
23C. PHYSICIAN'S NAME (Type) Ronald D. Snyder, M.D.				23D. ADDRESS University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12 June 67		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park	
24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR Robert E. Farkas	
25C. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5680 CERTIFICATE OF DEATH					Registered No. 67 5680				
BIRTH NO. M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>McDONALD, CHARLES EDWARD</u>					6/9/67 9:45 AM				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY OF MARYLAND Hosp. Lombard & Greene Sts. Balto.</u>					A. STATE <u>MARYLAND</u> B. COUNTY <u>Carroll Co.</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>SYKESVILLE</u> <u>56-00</u>				
					D. STREET ADDRESS (If rural, give location) <u>Box 11</u>				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>11/18/87</u>	<u>79</u>					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
<u>Painter</u>			<u>Painting</u>		<u>MD.</u>		<u>USA</u>		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
<u>CHARLES</u>					<u>Naomi Ellsworth</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
<u>No</u>			<u>220-07-1324</u>		<u>Chart</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO <u>Coronary Arteriosclerosis & Portal Hypertension</u>				
ANTECEDENT CAUSES					(B) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<u>Ante-mortem Cardiac Disease</u>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
<u>6/6/67</u>		<u>Scrofulous Abscess</u>		<u>No</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from <u>5/24/67</u> 19 <u>67</u> to <u>6/9</u> 19 <u>67</u> . that (I) (we) last saw the deceased alive on <u>6/9</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
<u>Irvin M. Sopher M.D.</u>					<u>6/9/67</u>				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
<u>IRVIN M. SOPHER</u>					<u>University Hosp. Balto. Md.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
<u>BURIAL</u>		<u>6-12-67</u>		<u>Springfield Cemetery</u>		<u>Sykesville Md.</u>			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS				
<u>JUN 13 1967</u>			<u>Robert E. Feltner</u>		<u>Harry W. Haight Sykesville, Md.</u>				

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BIRTH NO. 67 5681		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5681	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
		WILLIE Lester JOHNSON		6-10-67 8:02 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		A.A.C.	
33 399 JOHNS HOPKINS HOSPITAL - DOA		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		Pasadena 52-00	
		D. STREET ADDRESS (If rural, give location)		Box #68- Rte. #11	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	White	Married	Nov 21 1937	29	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Inspector		Balto Paper Box Co.		Tennessee	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Wyllie Johnson		Mattie ?		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		415-56-4315		Pasadena	
		Mr. Henry C. Johnson		2605 223rd St. Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Road		U.S. Rte. #1 - 27' South of NewCut Road - Kingsville, Maryland	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Driver of Honda motor-cycle in collision with Station Wagon	
6 10 '67 7:20 PM					
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		6-11-67	
RUSSELL S. FISHER, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		6/14/67		Glen Haven Memorial Park	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
JUN 13 1967		Robert E. Taylor, M.D.		McGully Funeral Home	
				ADDRESS	
				Patapsco & Thiel Brooklyn	

1985-1986

33

WALLACE POLICE

OFFICE

[Signature]

WALLACE POLICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5682	
BIRTH NO. 67 5682		CERTIFICATE OF DEATH		67 5682	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Mr Charles Wright Hoare</i>		2. DATE AND HOUR OF DEATH <i>June 9, 1967 9:25 P. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>409 West 28th Street</i>		12-07	
5. SEX <i>Male</i>	6. RACE <i>Caucasian</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>11/10/08</i>	9. AGE (In years last birthday) <i>58</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William A. Hoare</i>		14. MOTHER'S MAIDEN NAME <i>Corra Carson</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>214-05-3516</i>		17. INFORMANT <i>Mr Herbert W. Hoare</i> ADDRESS <i>914 W. 38th St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Lamenc's Cirrhosis</i> (B) <i>Bronchopneumonia</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>Several yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from <i>6/4</i> 19 <i>67</i> to <i>6/9</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6/9</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nate E. Watson, Jr.</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/9/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR NAT E. WATSON JR</i>		23D. ADDRESS M.D. <i>THE UNION MEMORIAL HOSPITAL</i>			
24A. CREMATION (Specify) <i>BURIAL</i>		24B. DATE <i>6/13/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>GREENMOUNT</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>		25A. DATE RECEIVED <i>JUN 13 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Paul E. Chapman</i>		ADDRESS <i>3614 Chester Ave.</i>			

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When I arrived at the hospital
I was told that the patient
was in a bad way
and I was told that the patient
was in a bad way
and I was told that the patient
was in a bad way

James's father's name is
James's father's name is
James's father's name is
James's father's name is

That's what I
want to know
That's what I
want to know

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 5683**BIRTH NO. **67 5683**

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

KATHRYNE**T.****MARKWOOD**

2. DATE AND HOUR PRONOUNCED DEAD

June 9, 1967**11:00 A.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)**910 W. Lombard Street**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

910 W. Lombard Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (Specify)**Separated**

8. DATE OF BIRTH

6-7-19219. AGE (In years
last birthday)**46**If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**Receptionist**

10B. KIND OF BUSINESS OR INDUSTRY

Doctors Office

11. BIRTHPLACE (State or foreign country)

W-Va-12. CITIZEN OF
WHAT COUNTRY**USA**

13. FATHER'S NAME

John E. Kearney

14. MOTHER'S MAIDEN NAME

Catherine Mansel15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)**No**16. SOCIAL
SECURITY NO.17. INFORMANT
ADDRESS
Mary Louise Nicholson - Olm

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) **Barbiturate Overdose and Acute
Alcoholic Intoxication**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

219B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?**Yes**21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)**Home**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

910 W. Lombard Street21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
Unk

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

**Ingested an overdose
of barbiturates along with alcohol**

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Werner U. Spitz, M.D.CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/9/6723A. BURIAL CREMATION
REMOVAL (Specify)**Burial**

23B. DATE

6/12/67

23C. NAME OF CEMETERY or CREMATORY

Glen Haven

23D. LOCATION

(City, town, or county)

Glen Burnie Md

24A. DATE REC'D BY HEALTH DEPT.

JUN 13 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

John J. Curran & Son Inc

ADDRESS

Baltimore Md

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5684		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 34-75-04	
M.E. CASE NO.		CERTIFICATE OF DEATH		67 5684	
1. NAME OF DECEASED (Type or Print) GORSKY, WALTER		2. DATE AND HOUR OF DEATH 6/4/67 6:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND University Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 642 S. BELNORD AVE			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7/8/02	9. AGE (In years last birthday) 64	10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10B. KIND OF BUSINESS OR INDUSTRY NATIONAL CAR		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ANTHONY GORSKY		14. MOTHER'S MAIDEN NAME VICTORIA BUNK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. —		17. INFORMANT admission record	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 163X I		CAUSE OF DEATH (A) Respiratory insufficiency (B) Cerebral of Lung (C) unknown		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		gastric hemorrhage & transfusion reaction			
19A. DATE OF OPERATION 2/19/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cerebral of Lung / GI bleeding		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/10 19 67 to 6/4 19 67 , that (I) we last saw the deceased alive on 6/4 19 67 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.					
23A. SIGNATURE Fred R. Eilber M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/4/67	
23C. PHYSICIAN'S NAME (Type) FRED R. EILBER		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-7-67		24C. NAME OF CEMETERY or CREMATORY Sacred Heart	
24D. LOCATION (City, town, or county) Balto Ct and		(State) md			
25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Robert E. Johnson	
				ADDRESS 3525 Fleet St #32	

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Released by DA Spitz for Approval.
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5685	
BIRTH NO. 67 5685				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BARNHART AUDREY K.		2. DATE AND HOUR OF DEATH 6/8/67 10:45p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Allegheny		C. CITY OR TOWN (If outside city limits, write RURAL and give township) CUMBERLAND 37-022	
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		D. STREET ADDRESS (If rural, give location) 201 Springdale St.		E. AGE (If lost birth date) 34 32	
5. SEX F	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12/24/34	9. AGE (If lost birth date) 34 32	10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State foreign country) Pa. Summit Mills, Pa.	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME CLYDE RINKER		14. MOTHER'S MAIDEN NAME IRENE MILLER	
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Wm. R. Barnhart, Cumberland, Md.-Husband	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., but means the disease, injury or complication which caused death) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause, or stating the UNDERLYING CONDITION		19. CAUSE OF DEATH (A) DUE TO Massive abd. bleeding due to rupture liver (B) DUE TO Mitral Valve prolapse for Recurrent Mitral Stenosis		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITION CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		20. MEDICAL CERTIFICATION OFFICE OF THE CHIEF MEDICAL EXAMINER 700 FLEET STREET BALTIMORE-2, MARYLAND			
19A. DATE OF OPERATION 6/8/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Heart disease		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/1 1967 to 6/8 1967, that (I) (we) last saw the deceased alive on 6/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. N. IRANI		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/8/67	
23C. PHYSICIAN'S NAME (Type) B. N. IRANI		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 12, 1967		24C. NAME OF CEMETERY or CREMATORY Salisbury, Pa. Cemetery	
24D. LOCATION Salisbury, Pa.		24E. DATE REC'D BY HEALTH DEPT. JUN 13 1967		24F. NAME OF REGISTRAR James F. Scarpelli	
24G. ADDRESS Cumberland, Md.		24H. NAME OF REGISTRAR James F. Scarpelli		24I. ADDRESS Cumberland, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5686	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 5686 G-350 </div>					
CERTIFICATE OF DEATH					
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) GUYTON RAYNOR S		JUNE 9 1967 8:10 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST AGNES HOSPITAL		A. STATE MD B. COUNTY PASADENA C. CITY OR TOWN (If outside city limits, write RURAL and give township) 52-00 D. STREET ADDRESS (If rural, give location) BOX 126 - Magothy Beach Road			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-16-01	9. AGE (In years lost birthday) 65	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver(ret)		10B. KIND OF BUSINESS OR INDUSTRY A.A. Co. Gov't.		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME HARRY J. Guyton			
14. MOTHER'S MAIDEN NAME MARY MARGARET TETLOW		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 214 01 6427		17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE.			
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 199.21 Carcinoma of neck (Rt side) and oropharynx					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Congestive Heart Failure			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 31 1967 to JUNE 9 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 9 1967 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (XXX) view the body after death.					
23A. SIGNATURE Wenifredo N. Iglesia				23B. DATE SIGNED 06-09-67	
23C. PHYSICIAN'S NAME (Type) WENIFREDO N. IGLESIA				23D. ADDRESS BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVES.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/13/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967			
25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Md.			

0225-5

BUCKET

ST. ANNE'S HOSPITAL

8-16-01

MAILED

WHITE

ST. ANNE'S HOSPITAL

ST. ANNE'S HOSPITAL

ST. ANNE'S HOSPITAL

ST. ANNE'S HOSPITAL

ST. ANNE'S HOSPITAL

10-10-01

ST. ANNE'S HOSPITAL

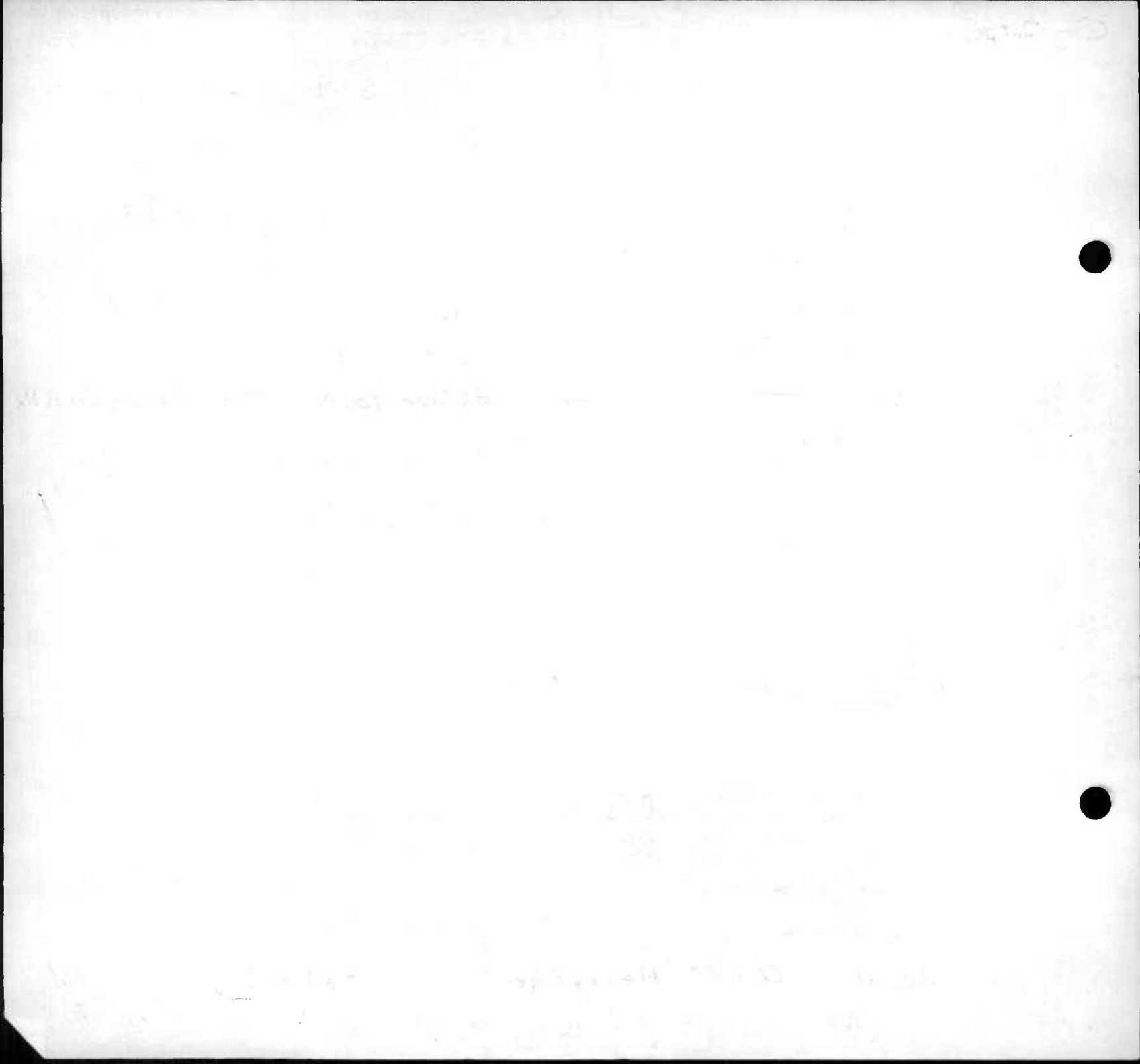
ST. ANNE'S HOSPITAL

ST. ANNE'S HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5687	
BIRTH NO. 67 5687		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Cook, Sandra Lee</u>		2. DATE AND HOUR OF DEATH <u>6-9-67</u> <u>8:30 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balt. Co.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>U. of Md. Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>53-00</u>			
		D. STREET ADDRESS (If rural, give location) <u>780 Charing Cross Rd.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>S</u>	8. DATE OF BIRTH <u>6-20-51</u>	9. AGE (In years last birthday) <u>15</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Arthur Cook</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Meek</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS <u>ARTHUR COOK 780 Charing Cross Dr</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>754.71</u>		CAUSE OF DEATH (A) <u>Subarachnoid Hemorrhage</u> (B) <u>A-V malformation</u> (C) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6-2-67</u> <u>6-9-67</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>6-3-67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Subarachnoid Hemorrhage</u>		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-2-67</u> to <u>6-9-67</u> that (I) (we) last saw the deceased alive on <u>6-9-67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>6-9-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Don G. Brannosen</u>				23D. ADDRESS <u>U. of Md. Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/13/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadow Ridge</u>	
24D. LOCATION (City, town, or county) (State) <u>Howard Co. Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 13 1967</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>301 Frederick Rd Baltimore</u>	

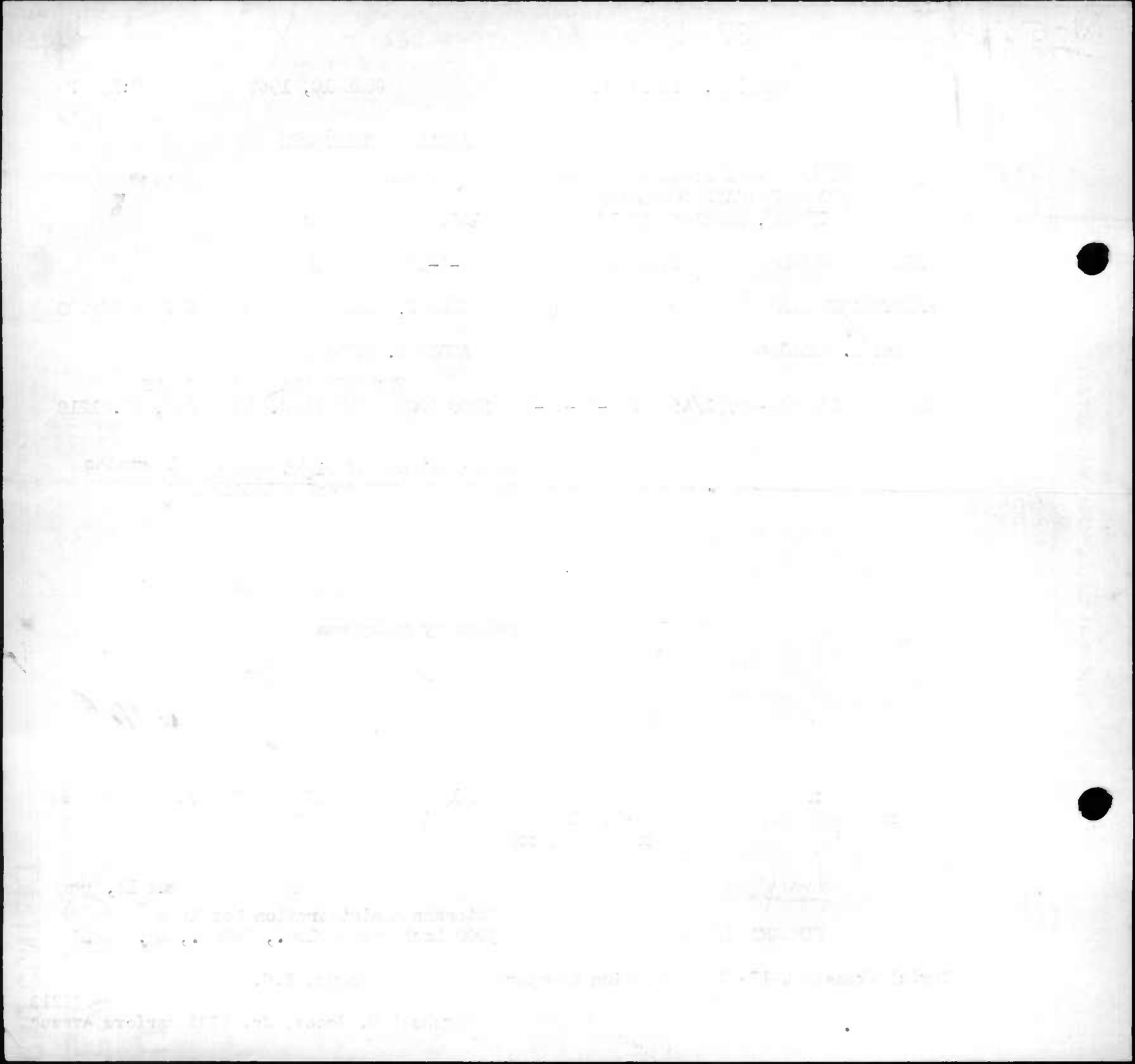


MI-551

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5688				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5688	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MANNING, WILLIAM L.				2. DATE AND HOUR OF DEATH JUNE 10, 1967 9:15 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1436 MAPLE AVENUE			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 8-9-16	9. AGE (In years lost birthday) 50	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN		10B. KIND OF BUSINESS OR INDUSTRY Real Estate Co		11. BIRTHPLACE (State or foreign country) CONWAY, SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME ROBERT L. MANNING				14. MOTHER'S MAIDEN NAME AGGIE N. STEWART			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 10/9/42-20/31/45		16. SOCIAL SECURITY NO. 250-18-55-09		17. INFORMANT VETERANS HOSPITAL RECORDS ADDRESS 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma of right upper lobe with widespread metastases INTERVAL BETWEEN ONSET AND DEATH 18 months ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary emphysema							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTAINING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that 1 (this hospital) attended the deceased from MARCH 15 19 67 to JUNE 10 19 67 , that we last saw the deceased alive on JUNE 10 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. 1 (We) (did) (do not) view the body after death.							
23A. SIGNATURE <i>Vincent Lopez</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 12, 1967	
23C. PHYSICIAN'S NAME (Type) VINCENT LOPEZ				23D. ADDRESS M.D. Veterans Administration Hospital 3900 Loch Raven Blvd., Balto., Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial-Transit		24B. DATE 6-17-67		24C. NAME of CEMETERY or CREMATORY Mt. Zion Cemetery		24D. LOCATION (City, town, or county) (State) Wampe, S.C.	
25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR Marshall W. Jones, Jr.		ADDRESS 21213 1735 Harford Avenue	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

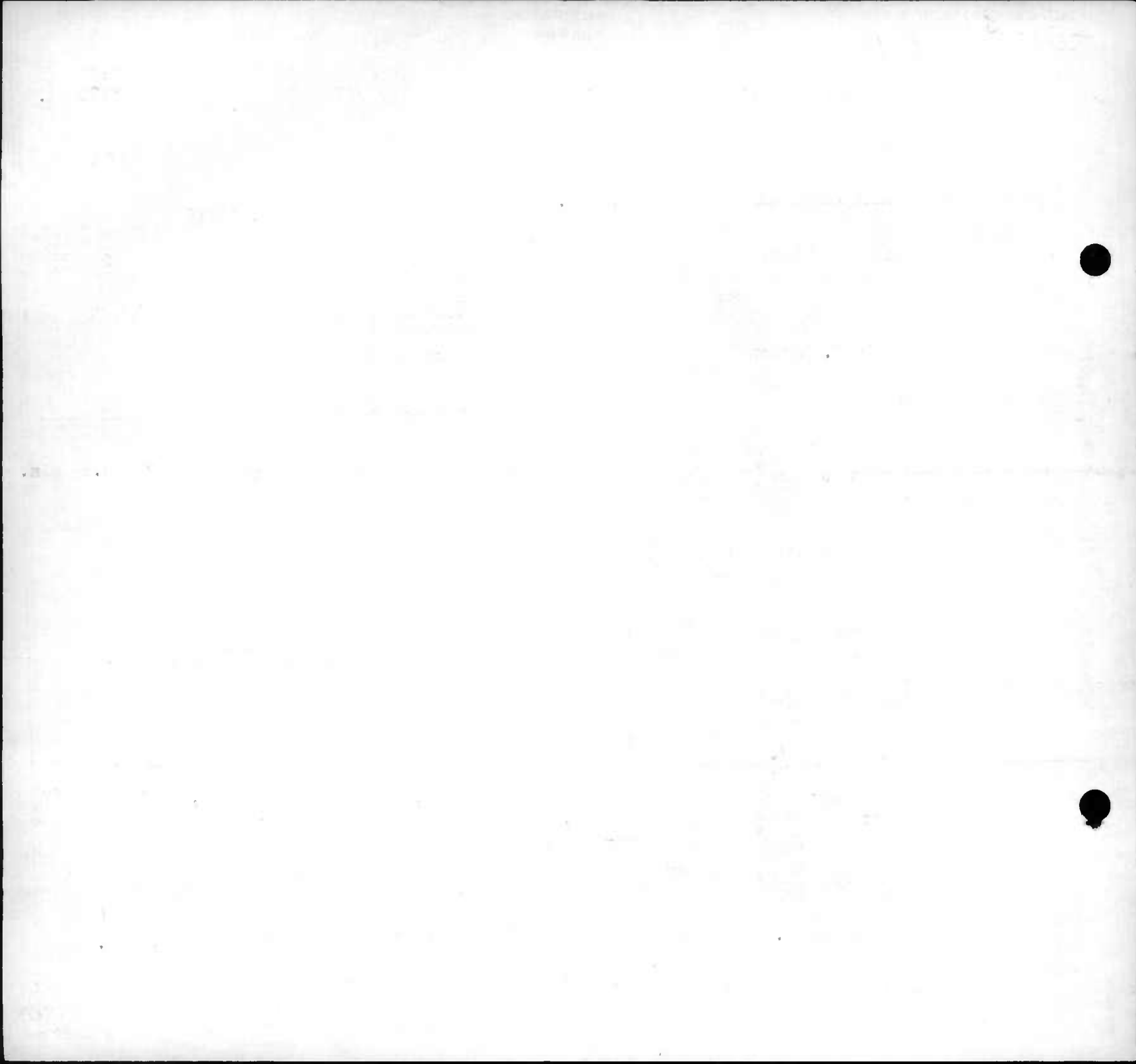
BALTIMORE CITY HEALTH DEPARTMENT										
67 5689					67 5689					
BIRTH NO.					CERTIFICATE OF DEATH					
M.E. CASE NO.					Registered No.					
1. NAME OF DECEASED (Type or Print) RITA WYATT					2. DATE AND HOUR OF DEATH 6/11/67 5:35 A M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL					A. STATE MARYLAND					
(If not in hospital or institution, give street address or location)					B. COUNTY Worcester Co.					
CMSC					C. CITY OR TOWN (If outside city limits, write RURAL and give township) OCEAN CITY 73-00					
					D. STREET ADDRESS (If rural, give location) 8 ST. LOUIS AVENUE					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) CHILD		8. DATE OF BIRTH 2/14/57	9. AGE (In years lost birthday) 10 yrs	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA (SALISBURY MD)			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Virgil WYATT					14. MOTHER'S MAIDEN NAME Edith HARMAN WYATT					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 10		17. INFORMANT Mrs. Edith Harmon Wyatt			ADDRESS OCEAN CITY MD		
18. 204.31					CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) CARDIAC ARREST DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) SEPSIS DUE TO 1 week					
					(C) LEUKEMIA - acute, cum cell 1 1/2 yrs					
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Thrombocytopenia										
19A. DATE OF OPERATION NO			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 5 1967 to June 11 1967 , that (I) (we) last saw the deceased alive on June 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Dr. Coussons					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6/11/67		
23C. PHYSICIAN'S NAME (Type) N. W. COUSSONS					23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 6/14/67		24C. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL			24D. LOCATION (City, town, or county) (State) BERLIN, WOR. CO. MD.		
25A. DATE RECEIVED BY HEALTH DEPT. JUN 15 1967			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Charles A. Burby			ADDRESS Berlin Md.	

Edith
H. H. H.

FUNERAL DIRECTOR: IMPORTANT

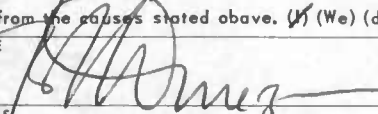
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

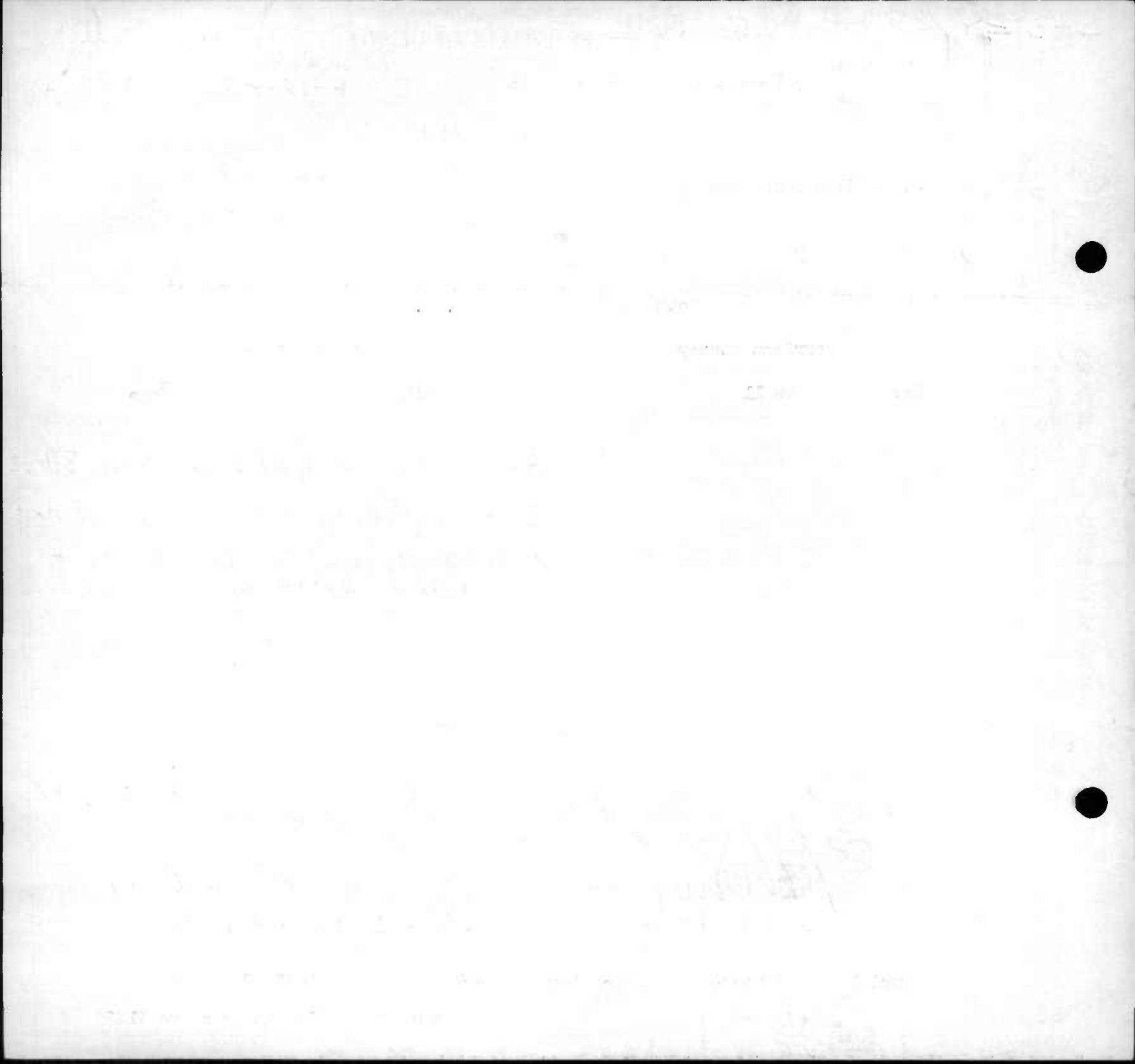
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5690</u>	
BIRTH NO. <u>67-11328 67 5690</u>		M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Lasson</u>			2. DATE AND HOUR OF DEATH <u>6/9/67</u> <u>7:20</u> <u>PM</u> A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital of Baltimore, Inc.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>6225 Highgate Drive, 21215</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>never married</u>	8. DATE OF BIRTH <u>6/9/67</u>	9. AGE (In years last birthday) <u>2</u> <u>35</u>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto, Md</u>	
13. FATHER'S NAME <u>Morris S. Lasson</u>			14. MOTHER'S MAIDEN NAME <u>Greta Wolse</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hosp Clerk</u>	
18. <u>759.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Multiple congenital anomalies</u> CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs. 35 min.</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>June 9, 1967</u> to <u>June 9, 1967</u> , that (I) <u>XX</u> last saw the deceased alive on <u>June 9, 1967</u> and that in (my) <u>for</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>for</u> (did) <u>XXXX</u> view the body after death.					
23A. SIGNATURE <u>Allan J. Monfried</u> M.D.				23B. DATE SIGNED <u>6/9/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Allan J. Monfried</u> M.D.				23D. ADDRESS <u>Sinai Hospital of Baltimore, Inc.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burned</u>		24B. DATE <u>6/9/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT Carmel</u>	
24D. LOCATION <u>Balto</u>		24E. LOCATION <u>Md</u>		24F. LOCATION <u>Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 13 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Tolson</u>		25C. FUNERAL DIRECTOR <u>Gybor S. Lewis & Son, Inc.</u>	
25D. ADDRESS <u>Gavison</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

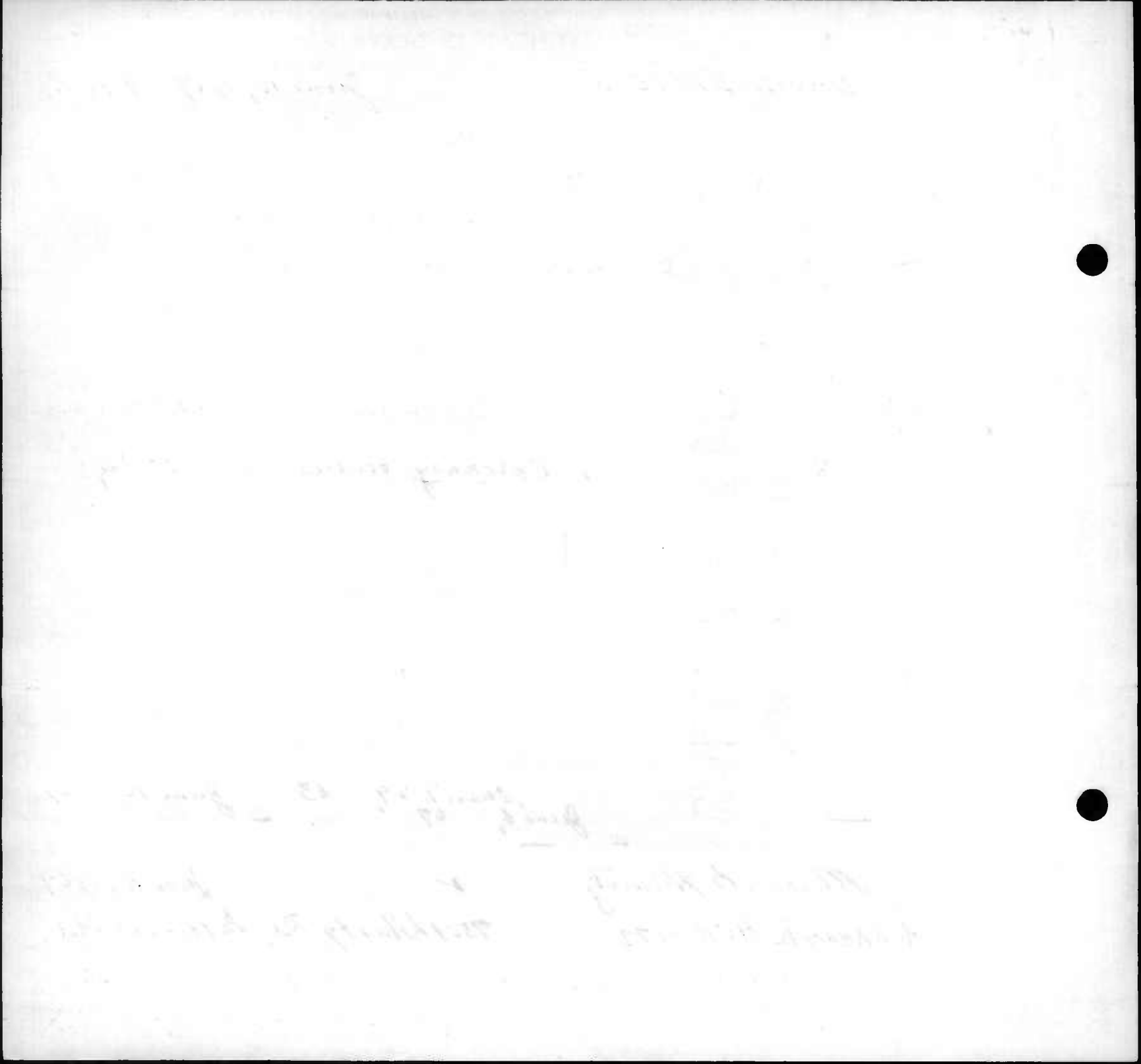
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5691	
BIRTH NO. 67 5691		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) STACEY, FOY B			2. DATE AND HOUR OF DEATH 6-10-67 430 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital of Md.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Balto. Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27 53-00 D. STREET ADDRESS (If rural, give location) 2914 Michigan Ave		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1-7-26	9. AGE (In years lost birthday) 41	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Beth Steel	11. BIRTHPLACE (State or foreign country) W.Va.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Harrison Stacey			14. MOTHER'S MAIDEN NAME Lydia Sullivan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO.	17. INFORMANT Family		ADDRESS Same
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ante Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 8 Hrs ±			(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH 8 Hrs ±		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) DUE TO Arteriosclerotic Cardio-vascular Disease INTERVAL BETWEEN ONSET AND DEATH 2 Yrs +		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6-9 1967 to 6-10 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6-9 1967 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED 6-10-67		
23C. PHYSICIAN'S NAME (Type) R. J. DUREZA			23D. ADDRESS M.D. 2413-A Cyllburn Ave. Baltimore 15		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/13/67	24C. NAME OF CEMETERY OR CREMATORY Lake view Mem Park	24D. LOCATION (City, town, or county) (State) Balto Co Md		
25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR Robert E. Talley	25C. FUNERAL DIRECTOR McGilly F H ADDRESS 237 Patapsco Ave 21225		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5692	
BIRTH NO. 67 5692		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DAVID EPSTEIN		2. DATE AND HOUR OF DEATH June 10, 1967 9:00 a. m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION KENESAW NURSING HOME		A. STATE MD		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO		15-38	
		D. STREET ADDRESS (If rural, give location) 2601 ROSLYN AVE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 1882	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT JEWSH FAMILY CARE
					ADDRESS 3750 PARK HEIGHTS AVE
18. 420.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Coronary occlusion		10 days	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO			
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 29, 1963 to June 10, 1967 , that (I) we last saw the deceased alive on June 6, 1967 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death.					
23A. SIGNATURE Abraham B. Hurwitz		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 10, 1967	
23C. PHYSICIAN'S NAME (Type) ABRAHAM B. HURWITZ		23D. ADDRESS 7501 Liberty Rd. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/67		24C. NAME OF CEMETERY or CREMATORY Wash Blvd	
24D. LOCATION (City, town, or county) (State) Balto MD					
25A. DATE RECEIVED BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Sigfried B. Lewis & Son, Inc	
				ADDRESS Gaithersburg MD	



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S-164

67 5693

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5693

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **LEROY SPRUILL** 2. DATE AND HOUR PRONOUNCED DEAD **June 11, 1967 11:10 P.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) **Maryland**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **Sinai Hospital (DOA)** 5. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

6. STREET ADDRESS (If rural, give location) **3430 Park Heights Avenue**

5. SEX **Male** 6. RACE **Negro** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Married** 8. DATE OF BIRTH **Dec. 26-43** 9. AGE (In years last birthday) **24**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Steel mill** 10B. KIND OF BUSINESS OR INDUSTRY **Steel mill** 11. BIRTHPLACE (State or foreign country) **MD.** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME **Eate Spruill** 14. MOTHER'S MAIDEN NAME **Locke**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **216-42-0332** 17. INFORMANT **Mother** ADDRESS **3430 Park Heights Ave**

18. CAUSE OF DEATH **Gunshot wound of neck**

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) **Gunshot wound of neck**

20. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO

21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **2** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **Autopsy** 20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. **sidewalk** 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **sidewalk** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **Front of 2808 Suffolk Avenue**

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) **6-11-67 10:50 P.** 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? **Shot during altercation**

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Springate** CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **June 12, 1967**

EXAMINER'S NAME (Type) **Charles S. Springate, M.D.** M.D. ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **JUN 13 1967** 23C. NAME of CEMETERY or CREMATORY **Not Calvary** 23D. LOCATION (City, town, or county) (State) **Baltimore, Md.**

24A. DATE REC'D BY HEALTH DEPT. **JUN 13 1967** 24B. NAME OF REGISTRAR **Robert E. Finkbeiner** 24C. FUNERAL DIRECTOR **R. Finkbeiner** ADDRESS **2700 Edmonson Ave**

VS 151-REV. 1/1/65

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VALLEY VIEW
WALLS & DINGLES

WALLS & DINGLES

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5694	
BIRTH NO. 67 5694		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH JUNE 7, 1967 4:10 P M.			
1. NAME OF DECEASED (Type or Print) VELONIS, COSTAS					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 231 NORTH MILTON STREET AVE.			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-7-09	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10B. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) GREECE	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME APOSTOLOS VELONIS			
14. MOTHER'S MAIDEN NAME TSINTSIRAS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 9/17/42-6/11/43			
16. SOCIAL SECURITY NO. 107-18-14-67		17. INFORMANT Veterans Hospital Records 3900 Loch Raven Blvd, Baltimore, Md. 21218			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC HEART DISEASE WITH CARDIAC ARREST		CAUSE OF DEATH PERICARDIAL EFFUSION		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO		1 WEEK	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		ADENOCARCINOMA OF LUNG WITH METASTASES		6 MONTHS	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that 10 (this hospital) attended the deceased from JUNE 5 19 67 to JUNE 7 , 19 67 , that 01 (we) last saw the deceased alive on JUNE 7 19 67 and that in 01 (my) (our) opinion death occurred on the date and hour and from the causes stated above. 11 (We) (did) not view the body after death.					
23A. SIGNATURE <i>Margaret A. Dennis</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/8/67	
23C. PHYSICIAN'S NAME (Type) MARGARET A. DENNIS		23D. ADDRESS VA HOSPITAL, 3900 LOCH RAVEN BLVD. BALTIMORE, MD. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-12-67		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967			
25B. NAME OF REGISTRAR Robert E. Edwards		25C. FUNERAL DIRECTOR Nicholas J. Matthews			
ADDRESS 3201 Eastern Ave., Baltimore, Md.					

1904, 2nd year

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5695 CERTIFICATE OF DEATH					Registered No. 67 5695				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Rose Benn					2. DATE AND HOUR OF DEATH June 11, 1967 1:15 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bolton Hill Nursing Home					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1610 Vincent Court 21217				
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8-15-94	9. AGE (In years last birthday) 72 72	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 219-30-1242A		17. INFORMANT ADDRESS Records: Bolton Hill Nursing Home				
18. 332X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral embolism DUE TO (A) Cerebral embolism (B) _____ DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE E. Ellsworth Cook M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/11/67		
23C. PHYSICIAN'S NAME (Type) E. Ellsworth Cook			23D. ADDRESS M.D. 2431 Madison Ave						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/67		24C. NAME of CEMETERY or CREMATORY Carver Mem. Park		24D. LOCATION (City, town, or county) (State) Laurel, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR Charles A. Rice		25C. FUNERAL DIRECTOR ADDRESS 661 W. Barre St.					

Conf. in Room

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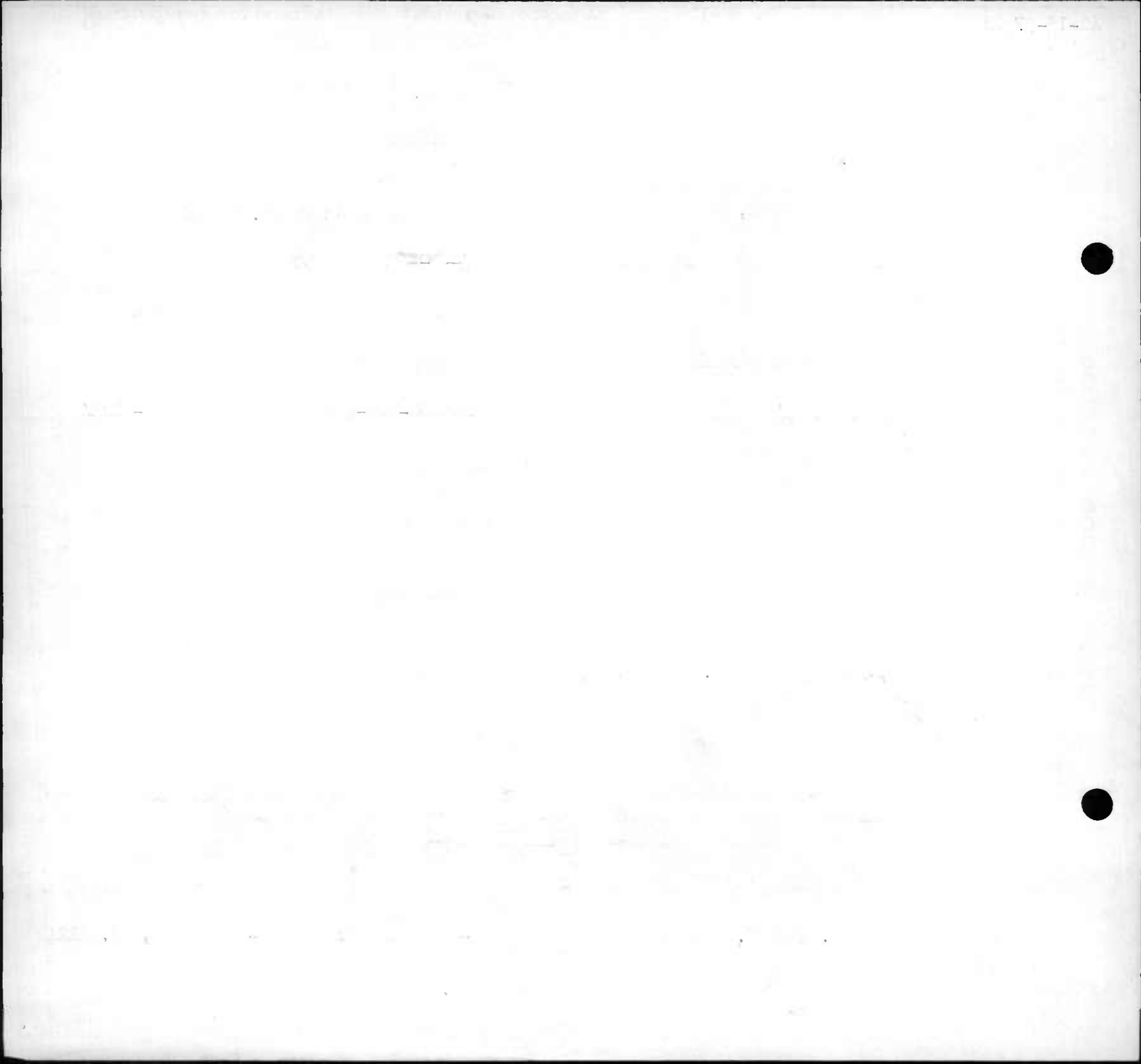
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5696	
BIRTH NO. 67 5696				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Theola Redfern (Theoler)		2. DATE AND HOUR OF DEATH 11 June 1967 530 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1607		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
D. STREET ADDRESS (If rural, give location) 1415 POPLAR GROVE ST. 21216					
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 4-20-21	9. AGE (In years lost birthday) 46	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN BLAKELY		14. MOTHER'S MAIDEN NAME EMMA McMANIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS-BCH-4940 EASTERN AVENUE -21224	
18. 154 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma of the Rectum - Invasive and metastatic 3-4 years INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Anemia					
19A. DATE OF OPERATION 0 1964		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 8 May 1967 to 11 June 1967 , that (I) was last saw the deceased alive on 10 June 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.					
23A. SIGNATURE Alan J. Barnes M.D.				23B. DATE SIGNED 11 June 1967	
23C. PHYSICIAN'S NAME (Type) DR. ALAN J. BARNES				23D. ADDRESS M.D. BCH-4940 EASTERN AVENUE-BALTIMORE, MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-18-67		24C. NAME OF CEMETERY or CREMATORY Goodman Creek Cem.	
24D. LOCATION (City, town, or county) (State) Cheraw, South Carolina					
25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Kelson Funeral Home 1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R 4001

67 5697

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 5697

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Edward Joseph Kelly, Jr

2. DATE AND HOUR OF DEATH

6-12-67 11:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

004005 Belview Ave

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MD 15-10
C. CITY OR TOWN (If outside city limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

4005 Belview Ave

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

5-17-1905

9. AGE (In years last birthday)

62

10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Self-employed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward J. Kelly, Jr

14. MOTHER'S MAIDEN NAME

Agnes F. Kelly

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-09-4944

17. INFORMANT

MARY C Kelly - Same

ADDRESS

18.

527.11

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Cor pulmonale
(B) Myocardial disease
(C) Pulmonary emphysema

INTERVAL BETWEEN ONSET AND DEATH

1 hr

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

A.V. Block

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/7/67 1967 to 6/13 1967, that (I) (we) lost saw the deceased alive on 6/11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Lee J. Volenick

M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

6/13/67

23C. PHYSICIAN'S NAME (Type)

Lee J. Volenick

M.D.

23D. ADDRESS

4710 LIBERTY HTS AU BALTO MD

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

6-15-67

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery - Baltimore, Md

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 13 1967

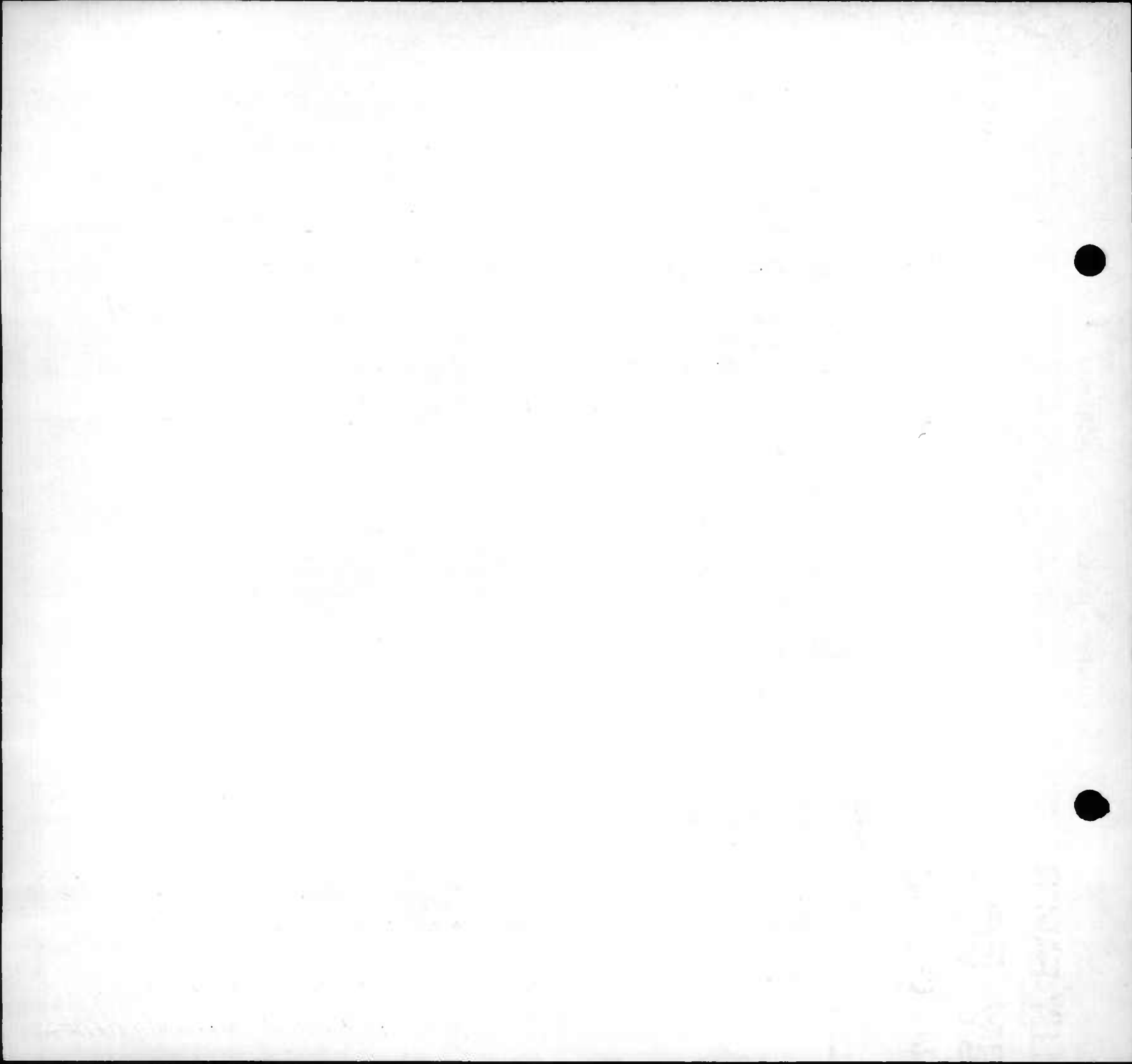
25B. NAME OF REGISTRAR

Robert E. Talley, Jr

25C. FUNERAL DIRECTOR

ELIZABETH ARMAGOST 4600 Liberty Hts

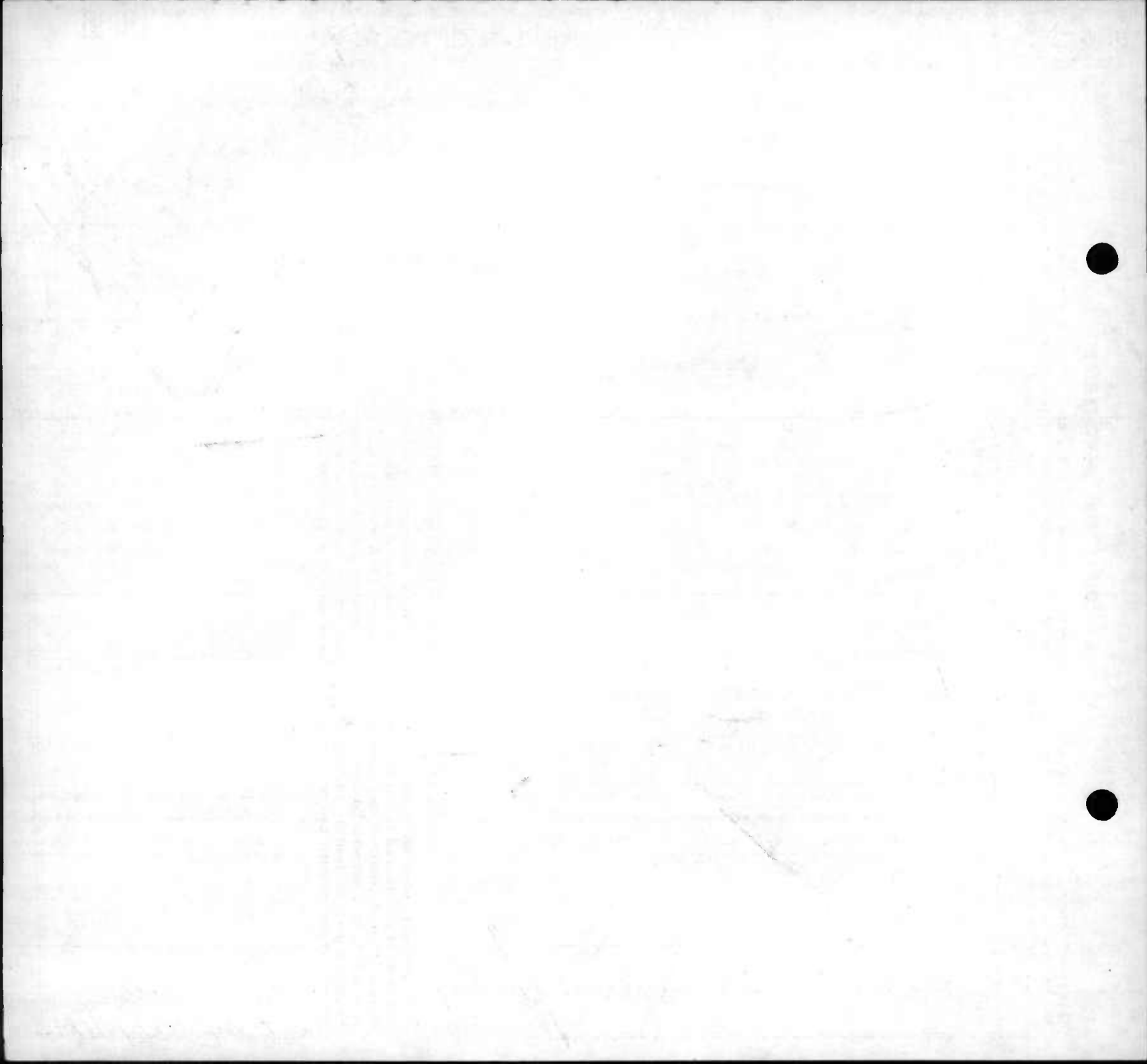
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No.	
67 5698						67 5698	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>GEORGE L. RICHARDS</u>				12 JUNE 1967 2:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MARYLAND GENERAL HOSPITAL</u> <u>48</u>				A. STATE <u>NORTH CAROLINA</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>KINGSTON</u> <u>V-30</u>			
				D. STREET ADDRESS (If rural, give location) <u>Route 3 - Box 283</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>5/10/98</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Policeman</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>FLETON B. RICHARDS</u>			14. MOTHER'S MAIDEN NAME <u>VIRGINIA LICKENS</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>MARY H. Richards - OWINGS</u>		
			ADDRESS <u>Rosewood Mills, MD</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>451 XI</u>			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <u>EXHAUSTION</u> DUE TO				
			(B) <u>LACKING ADDITIONAL BATT</u> DUE TO				
			(C) <u>FEVERISH</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>12 JUNE 1967</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Same as Above</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5 JUNE</u> 19 <u>67</u> to <u>12 JUNE</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12 JUNE</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>D. M. Barrick</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12 JUNE 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>DONALD M. BARRICK</u>				23D. ADDRESS M.D. <u>MARYLAND GENERAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6-15-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Evergreen Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Roanoke, VIRGINIA</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 13 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>ELSWORTH ARMACOST</u>		ADDRESS <u>4601 Liberty Heights</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-163

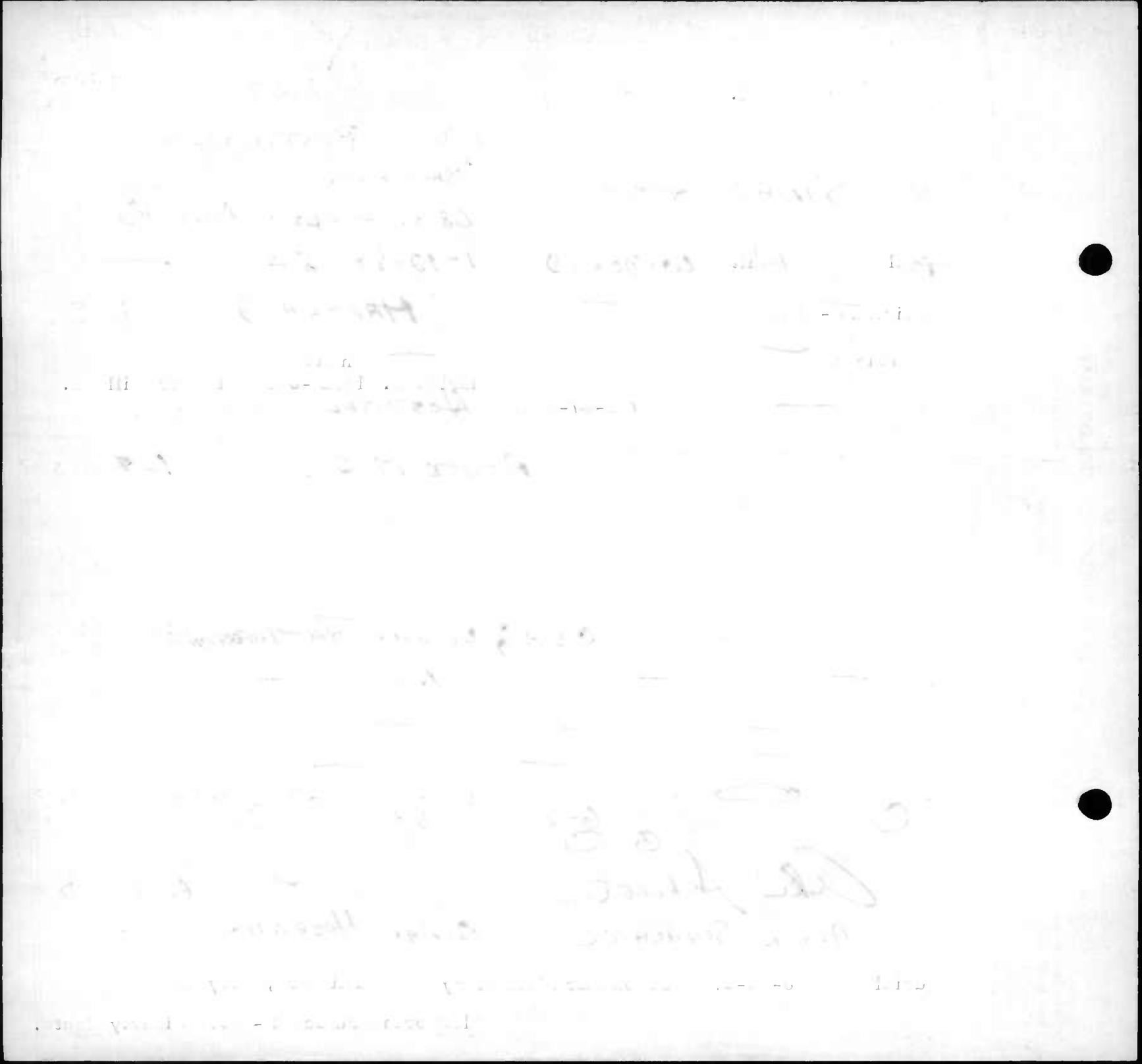
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5699	
BIRTH NO. 67 5699		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Sydney M. Beveridge		2. DATE AND HOUR OF DEATH 6-9-67 4:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 28-02			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 005123 Liberty Heights Ave		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 5123 Liberty Heights Ave			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH AUG 22, 1900	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME Joseph CARROLL		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-18-0495		17. INFORMANT ADDRESS Leolia SHAWVER - 902 St PAUL St	
18. 581.01		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cirrhosis of the Liver		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 year	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypochromic anemia, malnutrition			
19A. DATE OF OPERATION *****		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED *****		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) *****		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) *****		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) *****	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) *****		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? *****	
22. I certify that (I) (the hospital) attended the deceased from May 19 67 to June 19 67 , that (I) (the hospital) last saw the deceased alive on 6/7/67 19 67 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (the hospital) (did) (did not) view the body after death.					
23A. SIGNATURE Millard T. Traband, Jr. M.D.				23B. DATE SIGNED 6/9/67	
23C. PHYSICIAN'S NAME (Type) Millard T. Traband, Jr.		23D. ADDRESS 1811 North Rolling Road, Baltimore, Md. 21207			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6-13-67	24C. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR Robert E. Feltz		25C. FUNERAL DIRECTOR ADDRESS Elwood PARMACOST - 4600 Liberty Heights	



FUNERAL DIRECTOR: IMPORTANT

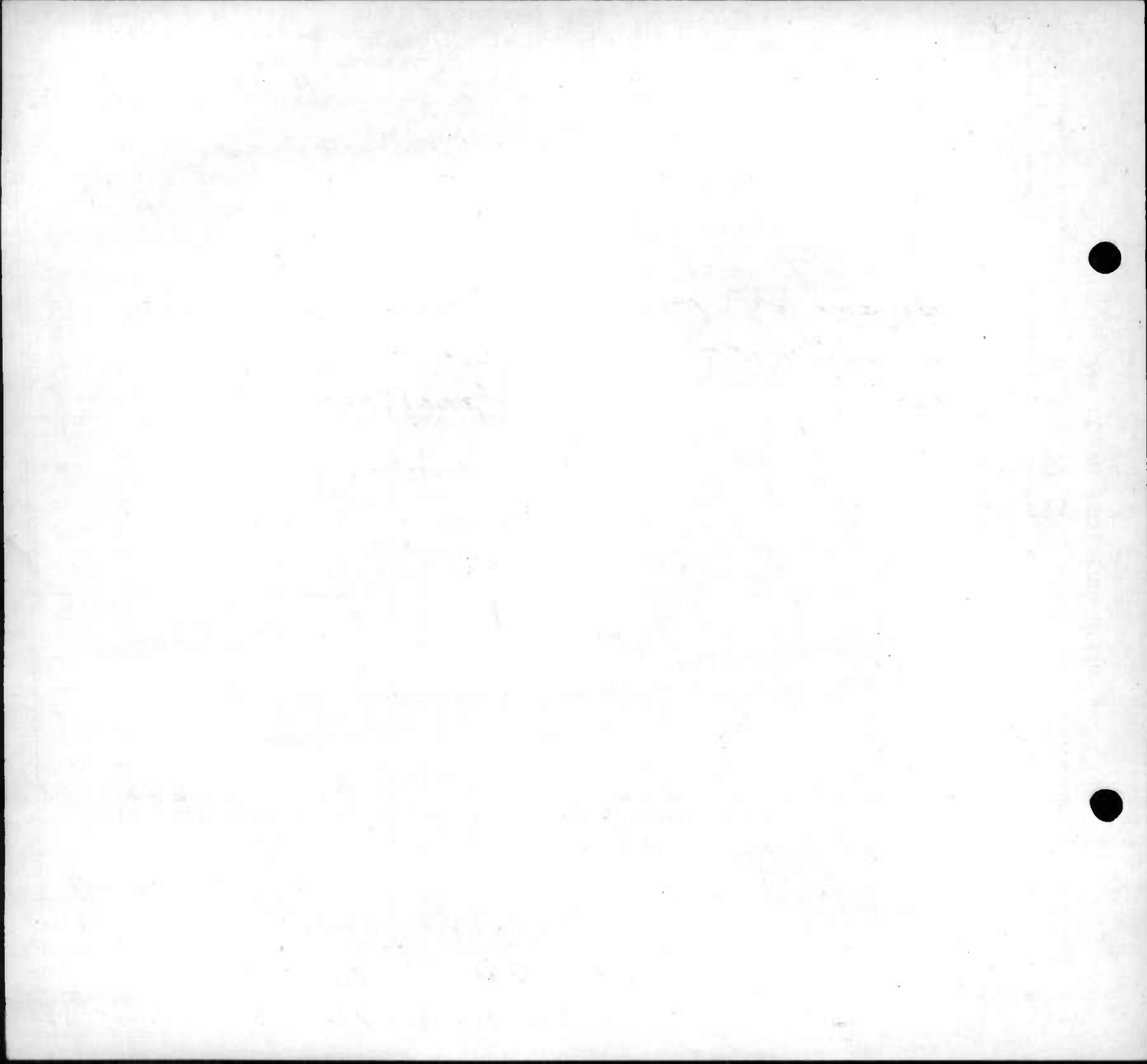
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5700	
BIRTH NO. 67 5700		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) CHARLES L. FLORA.		2. DATE AND HOUR OF DEATH 6-8-67 3:20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSP		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00			
		D. STREET ADDRESS (If rural, give location) 6830 WINDSOR MILL RD.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1-12-84	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months Days Hours Min. 11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman - B&O		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 705-07-2120		17. INFORMANT Charles L. Flora - 6830 Windsor Mill Rd. HOSPITAL CHART.	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) ACUTE M. 2		INTERVAL BETWEEN ONSET AND DEATH 12 HRS.?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CVA; URINARY TRACT INFECTION				24 HRS.	
19A. DATE OF OPERATION —		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 6-7 1967 to 6-8 1967, that (I) (we) last saw the deceased alive on 6-8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alvin Schachter M.D.				23B. DATE SIGNED 6-8-67	
23C. PHYSICIAN'S NAME (Type) ALVIN SCHACHTER		23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-12-67		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
				24D. LOCATION Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS Ellsworth Armacost - 4600 Liberty Hgts.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5701					67 5701				
BIRTH NO.					Registered No.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Smith, Susie A.					6-10-67 730 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
46 Lutheran Hospital of Md.					Md.				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore 16 15-06				
					D. STREET ADDRESS (If rural, give location)				
					2936 Westwood Ave.				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
F	C	Never Married	9-10-93	73					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Home maker			At Home		Odenton Md		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
John Smith					CLARA				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
no					KENNETH CARTER 1826 W BALTO. ST				
18. 2936 XI					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH				
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					(A) Severe Anemia, Chronic ?				
ANTECEDENT CAUSES					(B) Unknown cause ?				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Arteriosclerotic C-V disease Many years				
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
None					Yes				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
No									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?				
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (X) (this hospital) attended the deceased from 6-10 1967 to 6-10 1967, that (X) (we) last saw the deceased alive on 6-10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED	
R. J. DUREZA								6-10-67	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
					M.D. 2413-A Calburn Ave. Balto. Md 21215				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		6/14/67		Mt Auburn		Baltimore			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUN 13 1967		R. J. DUREZA		Kenneth Carter		1826 W BALTO. ST			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5702		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5702	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) GEORGE SMITH		2. DATE AND HOUR OF DEATH 6/12/67 12 25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-01 D. STREET ADDRESS (If rural, give location) 1601 Lorman Court			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH July 1926	9. AGE (In years lost birthday) 40	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO MD	
13. FATHER'S NAME JAMES SMITH		14. MOTHER'S MAIDEN NAME NELLIE CURTIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Patent	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Far advanced active tuberculosis		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH when - now	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 12 1967 to June 12 1967 , that (I) (we) last saw the deceased alive on June 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barry N. Rosenbaum M.D.		23B. DATE SIGNED 6/12/67		23C. PHYSICIAN'S NAME (Type) BARRY N. ROSENBAUM M.D.	
23D. ADDRESS UNIVERSITY HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/15/67		24C. NAME OF CEMETERY or CREMATORY WASTERN STAR	
24D. LOCATION (City, town, or county) (State) CATONSVILLE MD					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Anthony P. Smyth	
25D. ADDRESS 638 N. 6th St					

GEORGE SMITH

University Hospital

Mrs. Mayo

4/15/67

unpublished
letter

1001 Avenue Court

40

Letter

For archival action
reference

June 15 67
June 15 67

Barry N. Rosenbaum

Barry N. Rosenbaum

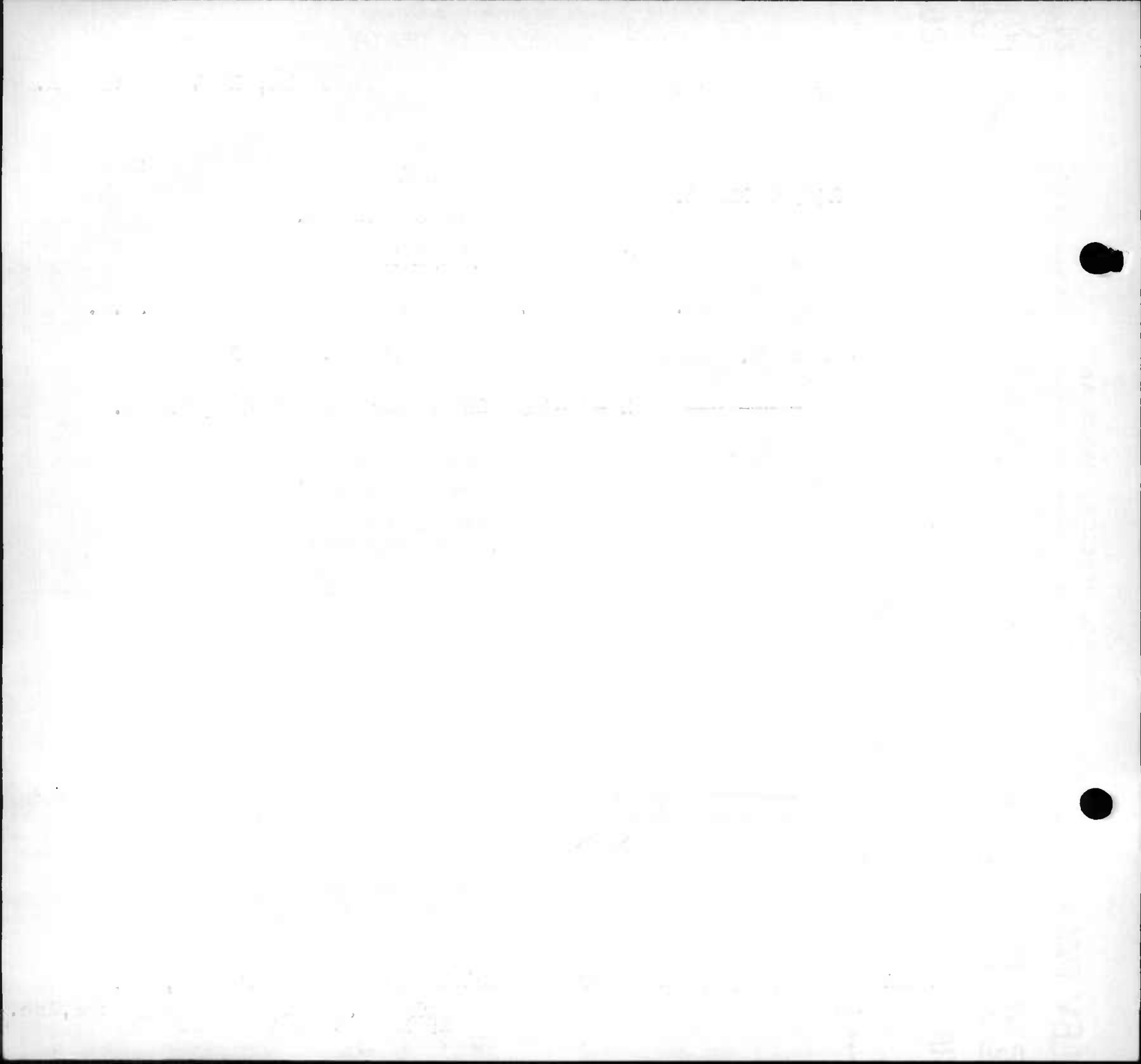
UNIVERSITY HOSPITAL

4/15/67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

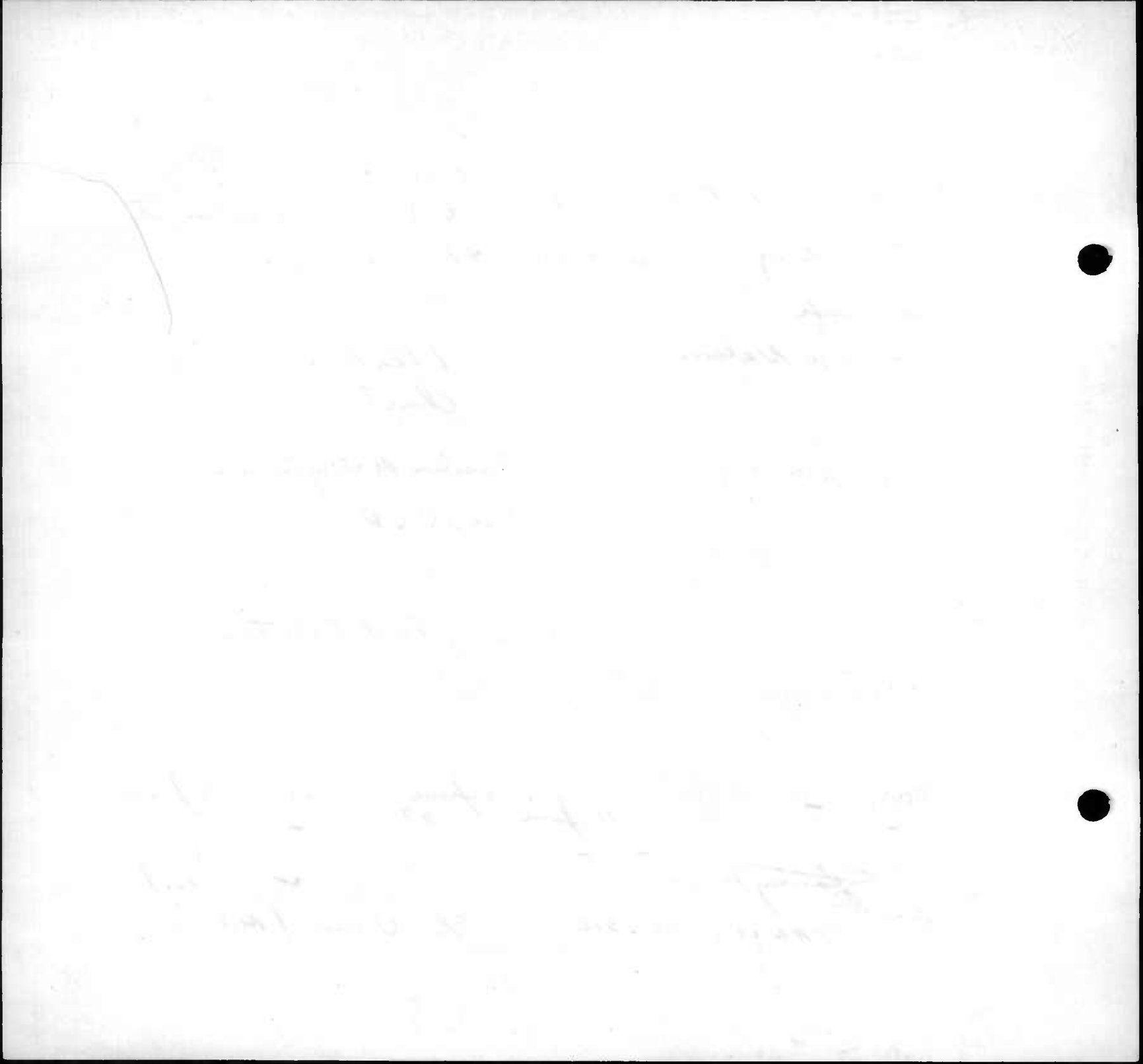
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5703	
67 5703				BIRTH NO.	
M.E. CASE NO.				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) Mary Margaret Shaw			2. DATE AND HOUR OF DEATH June 12, 1967 12:35 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1449 Hull St.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1449 Hull St.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/24/1910	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10B. KIND OF BUSINESS OR INDUSTRY St. Agnes Hosp.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME James E. Ross		
14. MOTHER'S MAIDEN NAME Mary R. Moreland			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 4080 218-28-106			17. INFORMANT ADDRESS Miss Lenora Ross 1449 Hull St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 12 yrs.			CAUSE OF DEATH (A) DUE TO heart disease (B) DUE TO pericarditis (C) DUE TO arteriosclerosis		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from March 1967 to June 11 1967, that (I) (we) last saw the deceased alive on June 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.		23A. SIGNATURE Romulo V. Goco M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23B. DATE SIGNED 6/12/67		23C. PHYSICIAN'S NAME (Type) Romulo V. Goco M.D.		23D. ADDRESS 5500 Bawlye Lane	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/15/67		24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park	
24D. LOCATION (City, town, or county) (State) Anne Arundel, Md.		25A. DATE RECD. BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR ADDRESS Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue					



FUNERAL DIRECTOR: IMPORTANT

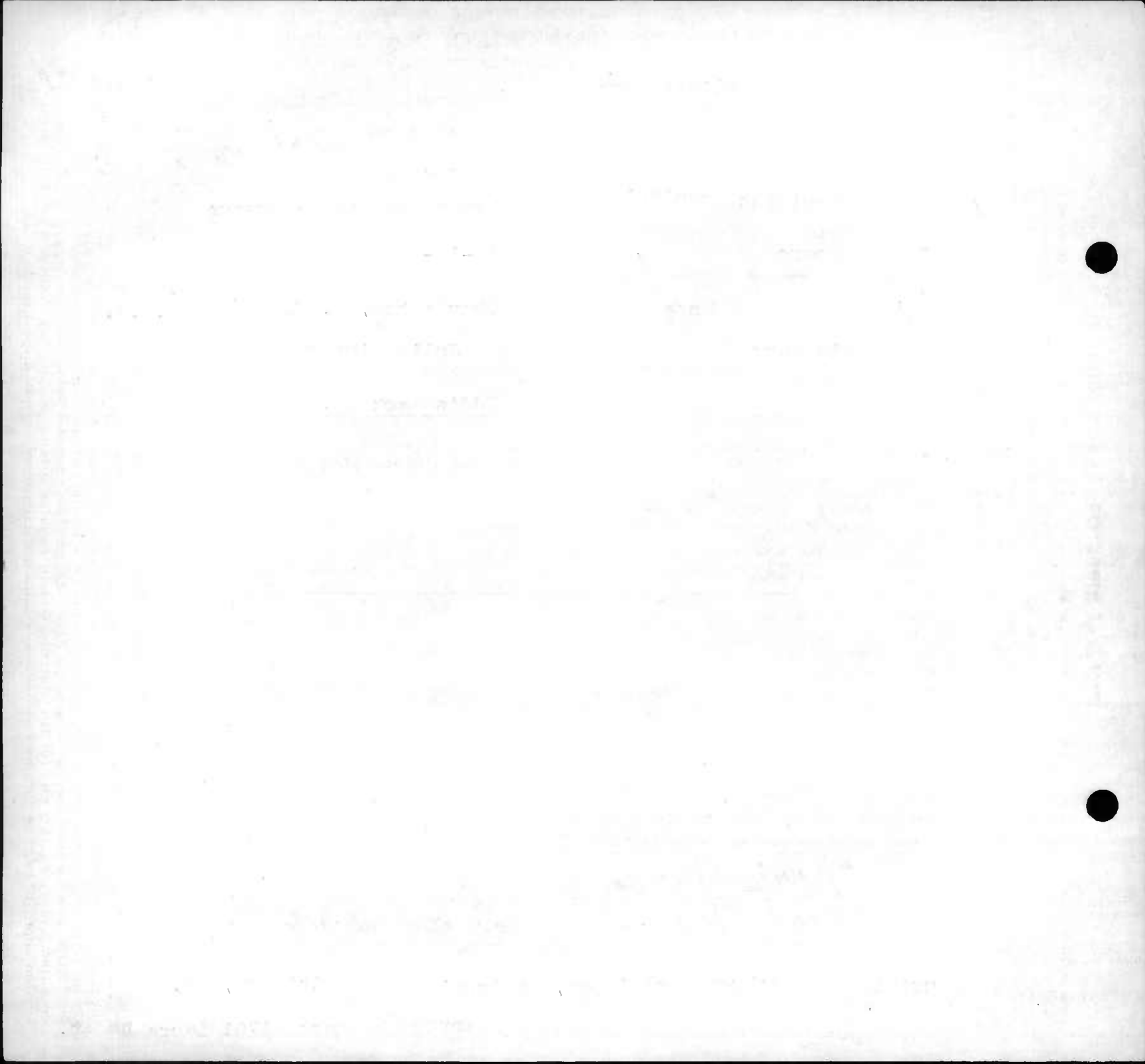
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5704					67 5704				
BIRTH NO.					REGISTERED NO.				
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) EVA MAE VELORDY					12 June 67 4 20 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIV OF MD Hosp					A. STATE MD B. COUNTY -				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO				
					D. STREET ADDRESS (If rural, give location) 819 W. Lexington St				
5. SEX ♀	6. RACE Neg	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8/4/98	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Nelson					14. MOTHER'S MAIDEN NAME Ells Mae Burley				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Chart		ADDRESS		
18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HA SCVD					CAUSE OF DEATH (A) Basilan Artery Thrombosis (B) HA SCVD (C) -		INTERVAL BETWEEN ONSET AND DEATH 9 days > 10 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Urinary Tract Infection							2 days		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 3 June 19 67 to 12 June 19 67 , that (I) (we) last saw the deceased alive on 11 June 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Stanley Music					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12 June 67		
23C. PHYSICIAN'S NAME (Type) STANLEY MUSIC					23D. ADDRESS % Univ of Md. Hosp				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/16/67		24C. NAME OF CEMETERY or CREMATORY MT. Auburn		24D. LOCATION (City, town, or county) (State) BALTO MD.			
25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Portions - Dept		ADDRESS 1701 LAURENS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

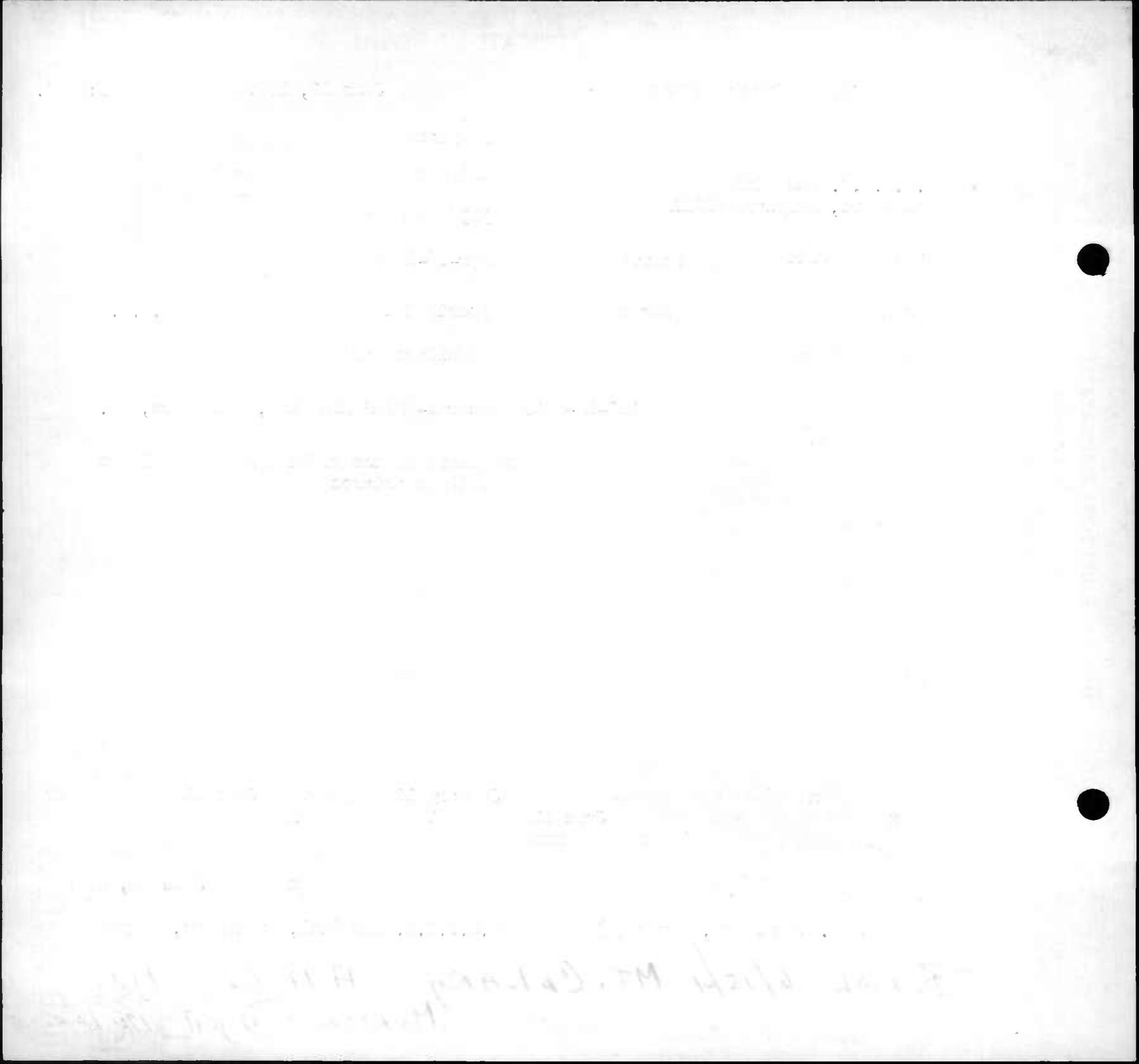
BIRTH NO. <i>Charleston, S.C.</i> 67 5705		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 5705	
1. NAME OF DECEASED (Type or Print) Felicia Mack				2. DATE AND HOUR OF DEATH 6/12/67 12:12 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2203 Lynn brook Avenue			
5. SEX Fe	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) N/A	8. DATE OF BIRTH 10-16-62	9. AGE (In years last birthday) 4	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		
11. BIRTHPLACE (State or foreign country) Charleston, S. C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Eddie Mack	
14. MOTHER'S MAIDEN NAME Julia Simmons			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N/A			16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Eddie Mack			ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Brain stem glioma				INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19__ to 19__, that (I) (we) last saw the deceased alive on 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Neal Aronson</i> M.D.				23B. DATE SIGNED 6/13/67		23C. PHYSICIAN'S NAME (Type) <i>Neal Aronson</i> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/67		24C. NAME OF CEMETERY or CREMATORY Baltimore, National		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR <i>R. E. E. Taylor</i>		25C. FUNERAL DIRECTOR Morton & Dyett		ADDRESS 1701 Laure ns St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5706	
BIRTH NO. 67 5706		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Antonio Garcia Bigzon		2. DATE AND HOUR OF DEATH June 12, 1967 5:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S.P.H.S. Hospital Baltimore, Maryland 21211		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3136 Sequoia Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Apr-16-1907	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boson		10B. KIND OF BUSINESS OR INDUSTRY Seaman		11. BIRTHPLACE (State or foreign country) Puerto Rico	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Antonio Bigzon			
14. MOTHER'S MAIDEN NAME Boniface Garcia		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 212-18-5423		17. INFORMANT ADDRESS Records-USPHS Hospital, Baltimore, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Carcinoma of the right lung with metastases		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from January 22 19 67 to June 12 19 67 , that (X) (we) lost saw the deceased olive on June 12 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.					
23A. SIGNATURE <i>Gerald D. Vermeulen</i> M.D.				23B. DATE SIGNED June 12, 1967	
23C. PHYSICIAN'S NAME (Type) Gerald D. Vermeulen, Surg (R)		23D. ADDRESS M.D. U.S.P.H.S. Hospital, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6/15/67	24C. NAME of CEMETERY or CREMATORY MT. CALVARY		24D. LOCATION (City, town, or county) (State) A.A.C., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 13 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS MORTON + DYETT 1701 LAURENS	



1
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67 5707

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5707

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PAUL R. THOMPSON

2. DATE AND HOUR PRONOUNCED DEAD

6-9-67

9:30 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

916 Kent Avenue Westview 21228

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

2/24/08

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Electrician

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Paul Bernard Thompson

14. MOTHER'S MAIDEN NAME

Clara - HIRICK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-22-7721

17. INFORMANT

Ann A. Thompson

ADDRESS

916 Kent Ave. 21228

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK

NOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

Russell S. Fisher

M.D.

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

6-10-67

EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/13/67

23C. NAME OF CEMETERY or CREMATORY

Glen Haven Cemetery

23D. LOCATION

Glen Burnie, Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 14 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Howard H. Hubbard
Funeral Home

ADDRESS

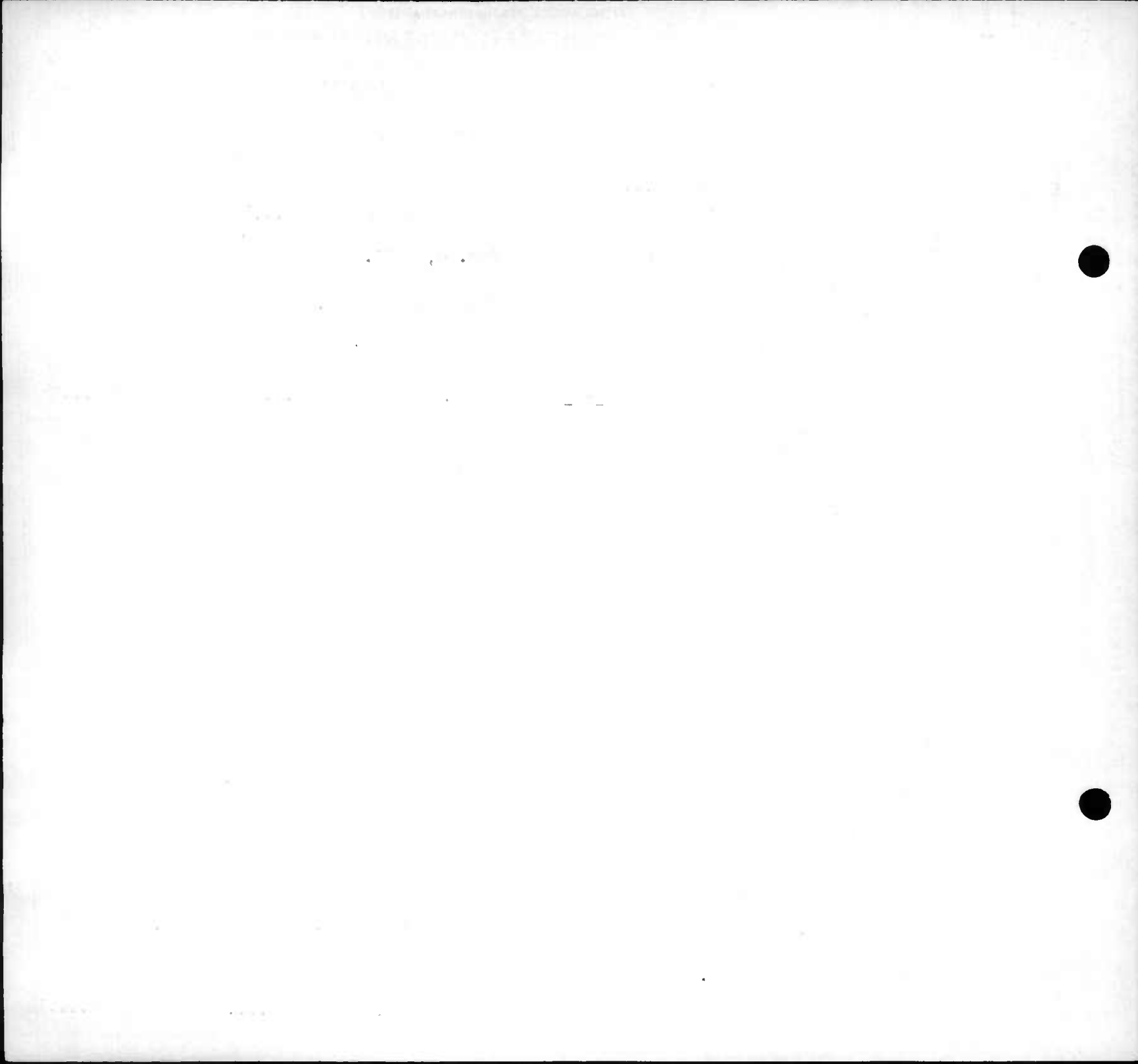
4107 Wilkens Ave. 21229

WATER
PROOF
PAPER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5708	
BIRTH NO. 67 5708				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SARAH E. KNIGHT			2. DATE AND HOUR OF DEATH June 13, 1967 4:50 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2807 Berwick Avenue...34			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2807 Berwick Avenue...34		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH Jan. 4, 1875.	9. AGE (In years last birthday) 92	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Jacksonville, Md.
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John Isenock		
14. MOTHER'S MAIDEN NAME Elizabeth Ann Coe			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 216-10-3200B			17. INFORMANT ADDRESS Mrs. Mary Berwager...2807 Berwick Ave...34		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			CAUSE OF DEATH (A) Arteriosclerosis DUE TO C.V. Disease (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21A. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21B. HOW DID INJURY OCCUR?		
21C. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21D. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 5/15 19 67 to 6/13 19 67 , that (I) (we) last saw the deceased alive on 5/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nathan Jamey			23B. DATE SIGNED 6/13/67		
23C. PHYSICIAN'S NAME (Type) Dr. Nathan Jamey			23D. ADDRESS 7101 Harford Rd, Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 6/16/67.	24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Maryland
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc....Baltimore, Md....74	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>Hagerstown, Md.</i> 67 5709		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5709	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) RANDY E. DIETRICH		2. DATE AND HOUR OF DEATH 6-11-67 8:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY WASHINGTON C. CITY OR TOWN (If outside city limits, write RURAL and give township) FUNKSTOWN 71-00 D. STREET ADDRESS (If rural, give location) BOX # 41			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) CHILD	8. DATE OF BIRTH 5-27-67	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GERALD			
14. MOTHER'S MAIDEN NAME SUZANNE SNYDER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None		17. INFORMANT Father			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Renal Shut down ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Gram Negative Sepsis Intrauterine Uterine		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 10 days 15 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Prematurity					
19A. DATE OF OPERATION 6-8-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intrauterine Uterine		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) No		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? No	
22. I certify that (I) (this hospital) attended the deceased from 6-6-67 19 67 to 6-11 19 67 , that (I) (we) last saw the deceased alive on 6-11-67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dietrich E. Brookhouse		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-11-67	
23C. PHYSICIAN'S NAME (Type) Dietrich E. Brookhouse		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/67		24C. NAME OF CEMETERY or CREMATORY Rest Haven Cemetery Hagerstown	
24D. LOCATION (City, town, or county) (State) Hagerstown Md					
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor, Md		25C. FUNERAL DIRECTOR Ralph M. Martin	
				ADDRESS 1601 Penning Ave	
				Hagerstown Md	
				Rest Haven Funeral Chapel	

B-500

67 5710

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5710

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDNA B. BOONE

2. DATE AND HOUR PRONOUNCED DEAD

June 11, 1967 9:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3815 Hayward Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

July 12, 1896.

9. AGE (in years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Walter H. Robinson

14. MOTHER'S MAIDEN NAME

Anne E. Laughlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217-48-1296

17. INFORMANT

ADDRESS

Mr. Kenneth E. Boone, Titusville, Florida.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springgate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 12, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/16/67.

23C. NAME OF CEMETERY or CREMATORY

Moreland Memorial Cemetery

23D. LOCATION (City, town, or county) (State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 14 1967

Robert E. Farley

Leonard J. Ruck, Inc. Balto. Md. 21214

100-100000

July 12, 1964

100-100000

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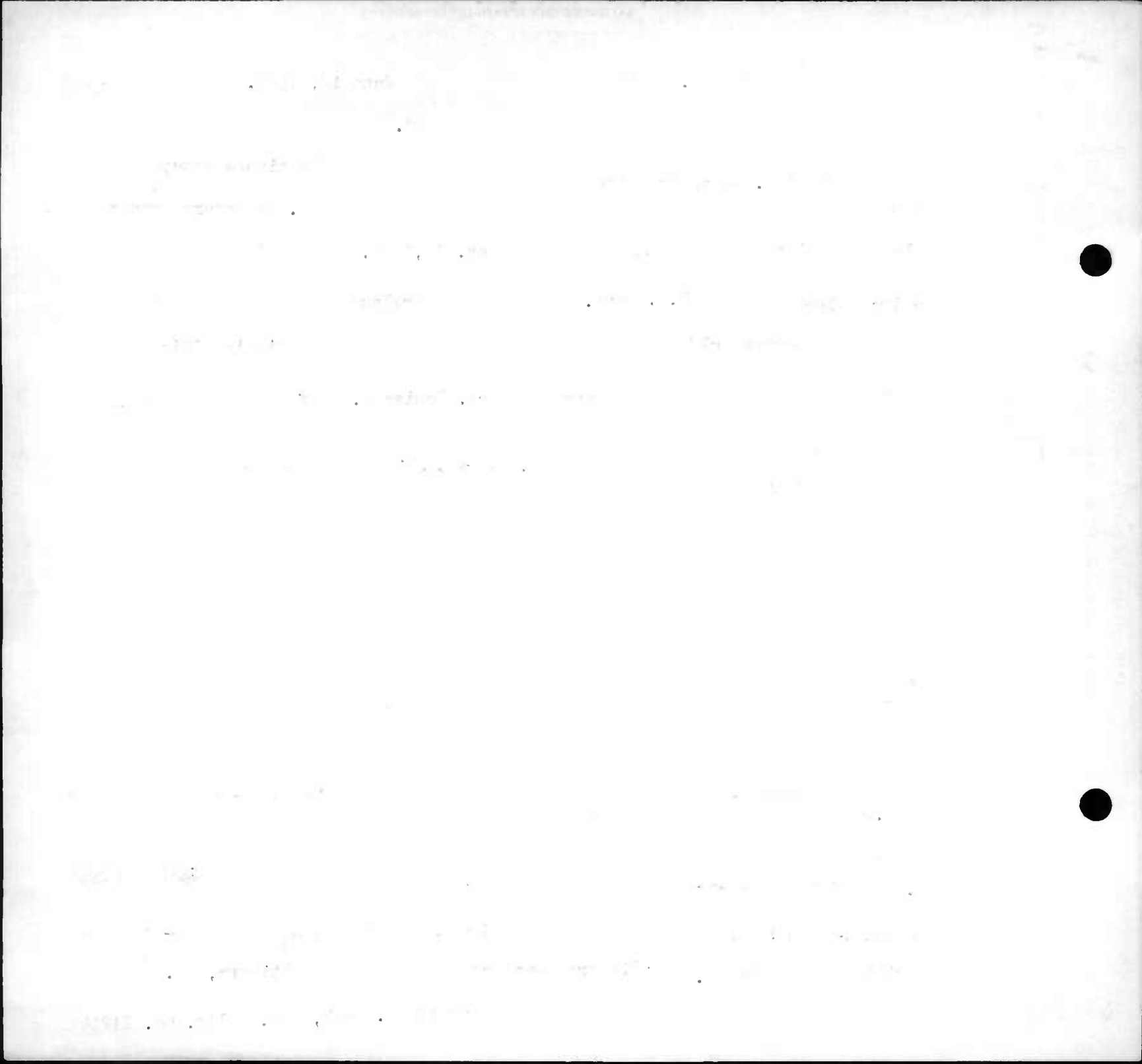
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5711 CERTIFICATE OF DEATH					Registered No. 67 5711				
BIRTH NO. M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) WALTER A. WOLF					June 12, 1967. 6:45A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 1101 E. Belvedere Avenue					A. STATE Md. B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21212				
					D. STREET ADDRESS (If rural, give location) 1101 E. Belvedere Avenue				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 16, 1885.	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk			10B. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Wolf					14. MOTHER'S MAIDEN NAME Minnie Ellis				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Louise B. Wolf		ADDRESS (Same)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.11 Enterococcal C.V.D.					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1956 to June 12 1967, that (I) (we) last saw the deceased alive on May 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. Henry Haase					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED JUN 13 1967	
23C. PHYSICIAN'S NAME (Type) J. Henry Haase					23D. ADDRESS M.D. 2926 E. Cold Spring Lane - Balto., Md				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/15/67.		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967			25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto., Md. 21214			ADDRESS	



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H-220

67 5712

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5712

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM TAFT HUGHES

2. DATE AND HOUR PRONOUNCED DEAD

6-12-67

10:25 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1400 BLOCK OF WARNER STREET - Amb. Crew #5

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

622 W. Conway Street 21230

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married

8. DATE OF BIRTH

9/28/42

9. AGE (In years
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Cluff Ruben Hughes

14. MOTHER'S MAIDEN NAME

Lillie Mae Remes

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lillie Mae Hughes 622 W. Conway St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO Overdose of narcotics

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Unknown

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Found: 1400 Block Warner Street

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year)

10:15

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Ingested overdose of narcotics

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

6-13-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/17/67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 14 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Charles A. Rice 661 W. Barre St.

ADDRESS

ALL PAPER

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5713		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 5713	
1. NAME OF DECEASED (Type or Print) <i>Ernest A. Weller</i>			2. DATE AND HOUR OF DEATH <i>6-11-67</i> <i>12³⁰</i> P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>			A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
D. STREET ADDRESS (If rural, give location) <i>973 North Hill Rd.</i>			9-01		
5. SEX <i>M.</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>1/11/12</i>	9. AGE (In years last birthday) <i>55</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Senior Elec. Engr.</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Gas & Elec. Co</i>		
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Ernest A. Weller</i>			14. MOTHER'S MAIDEN NAME <i>Edith M. Reese</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>212-05-4763</i>		
17. INFORMANT <i>Mrs. Gertrude M. Weller</i>			ADDRESS <i>Rd. 973 North Hill</i>		
18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Cerebral Artery Occlusion</i> DUE TO (B) <i>Cerebral Myocardial Infarction</i> DUE TO (C) <i>ASCVD</i>		
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>January 26, 1967</i> to <i>June 30, 1967</i> , that (I) (we) last saw the deceased alive on <i>June 30, 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Anthony M. Celligro</i>				23B. DATE SIGNED <i>6/13/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Anthony M. Celligro</i>				23D. ADDRESS <i>8155 Loch Raven Blvd.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/14/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Memorial Park</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 14 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>John T. Moran, Inc.</i>	
25D. ADDRESS <i>3000 E. Baltimore St.</i>					

6-11-20

1000 ft. to 1000 ft.

1000 ft. to 1000 ft.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5714	
67 5714				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Stallings, Bertha J.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH			
		6/11/67 14:45 P.M.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE B. COUNTY			
Sinai Hosp of Balt		Maryland, Baltimore Co			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Owings Mills 53-09			
		D. STREET ADDRESS (If rural, give location)			
		11005 Reisterstown Rd			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F	w	WIDOWED	3/2/90	77	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		—		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
CALVIN R. Jeffery		Roberta Lee Warfield			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		None		Mr. Brent Stallings	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) CVA			
ANTECEDENT CAUSES		(B) H A S H D			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 6/11 19 67 to 6/11 19 67, that (1) (we) last saw the deceased alive on 6/11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
David A. Spott M.D.				6/14/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
D.A. SPOTT		Sinai Hosp of Balt			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/14/67		Mountain View Cemetery	
				Howard Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 14 1967		Robert E. Fairbank		H.J. Sechardt	
				Owings Mills, Md	

No
 Calvin R Jeffery
 Maryland
 Robert R. Warfield
 N 2 A
 Mr. Brent Stallings
 15002 Rockledge Rd
 Camp Hill, Pa

Brian
 Charles Mountain View Country
 Howard G. Maryland
 47300000 Camp Hill, Pa

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

49-45-49 |

IW

16-635

67 5715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 5715

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

DOVIE HARDIN

2. DATE AND HOUR OF DEATH

6-11-67

1 15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MARYLAND

B. COUNTY

BALTIMORE Co

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

D. STREET ADDRESS

(If rural, give location)

1956 EWALD AVENUE - 21222

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

9/16/02

9. AGE (In years
last birthday)

64

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JAMES

ROBERTS

14. MOTHER'S MAIDEN NAME

XXXXX

EVIRA

ELLIS

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

unknown

17. INFORMANT

ADDRESS

RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224

18. 422.1 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

2 days

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) this hospital attended the deceased from 6-9 19 67 to 6-11 19 67,
that (I) last saw the deceased alive on 6-11 19 67 and that in (my) opinion death occurred on the date
and hour and from the causes stated above. (I) (X) (did) (did not) view the body after death.

23A. SIGNATURE

James T. Corkins

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6-11-67

23C. PHYSICIAN'S
NAME (Type)

JAMES T. CORKINS

M.D.

23D. ADDRESS

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue, Balto. Md. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/17/67

24C. NAME OF CEMETERY or CREMATORY

Valleytown Cemetery

24D. LOCATION

(City, town, or county)

(State)

Andrew, North Carolina

25A. DATE REC'D BY HEALTH DEPT.

JUN 14 1967

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

P. Singleton

Singleton Funeral Home
Glen Burnie, Md.

6-11-01

10-11-01

General Manager, Springfield, Mass.

ASCD

10-11-01

10-11-01

10-11-01

James A. Robinson

6/1/02

Wright

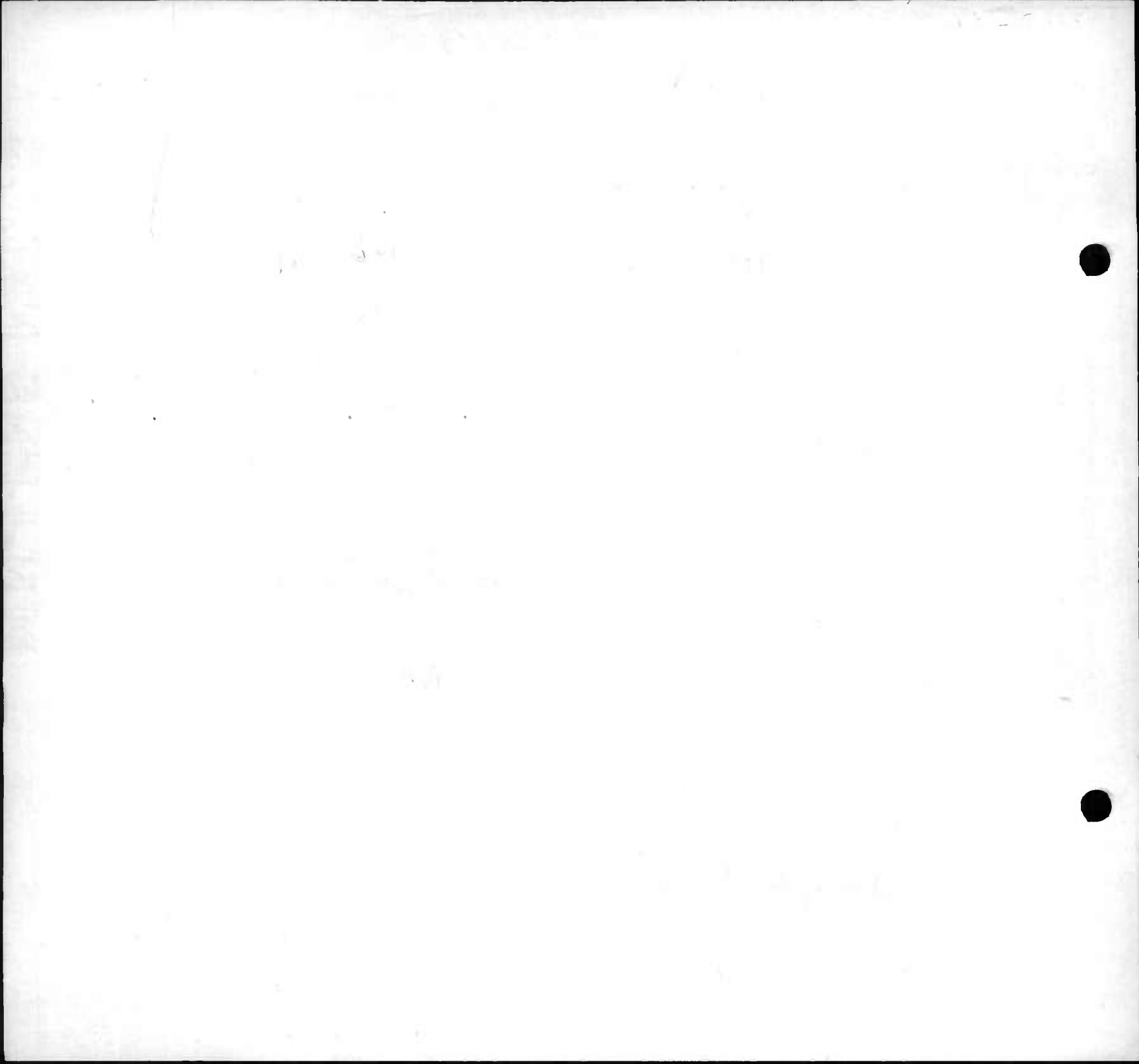
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 5716		67 5716		67 5716	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>EMILY W. Gintling</i>			2. DATE AND HOUR OF DEATH <i>6-12-67 10⁵⁵ A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <i>49 North Charles Gen. Hosp.</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
			D. STREET ADDRESS (If rural, give location) <i>3011 Echodale Ave. 21214</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH <i>9-24-1902</i>	9. AGE (In years last birthday) <i>64</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Drapery Business</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Edward Unglesbee</i>		14. MOTHER'S MAIDEN NAME <i>Lillie Penn Duvalle</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Dr. Roubinoff</i> ADDRESS <i>N. Ch. G. H.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>162.1 I</i>			CAUSE OF DEATH (A) <i>Massive metastatic ca. liver - recent</i> (B) <i>Bronchogenic Ca.</i> (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>4/19</i> 19 <i>67</i> to <i>6/12</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6/12</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Robert Rubenoff</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/12/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>MARION FRIEDMAN</i>		M.D.		23D. ADDRESS <i>North Charles General Hosp.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/15/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>JUN 14 1967</i>		25B. NAME OF REGISTRAR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>	
25C. FUNERAL DIRECTOR		ADDRESS			

5/12 12 PM

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5717	
BIRTH NO. 67 5717		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) REGINA GEBHARDT		2. DATE AND HOUR OF DEATH June 9, 1967, 8 ⁰⁰ /P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		701	
		D. STREET ADDRESS (If rural, give location) 3115 E. MONUMENT STREET 21205			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 03/31/86	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE SAUER		14. MOTHER'S MAIDEN NAME CATHERINE WOLDECK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Martin A. Gebhardt 3115 E. Monument St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 331X1		CAUSE OF DEATH (A) DUE TO Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Arteriosclerotic Vascular Disease			
		(C) DUE TO Multiple CVA's			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from May 1, 1967, to June 9, 1967, that (we) last saw the deceased alive on June 9, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Silva		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 9, 1967	
23C. PHYSICIAN'S NAME (Type) JOSEPH SILVA		23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/13/67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
		24D. LOCATION Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR Robert E. Fulkerson		25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.	



APPROVAL OF MEDICAL EXAMINER: DR. HIRSCH- RELEASED
FUNERAL DIRECTOR: IMPORTANT

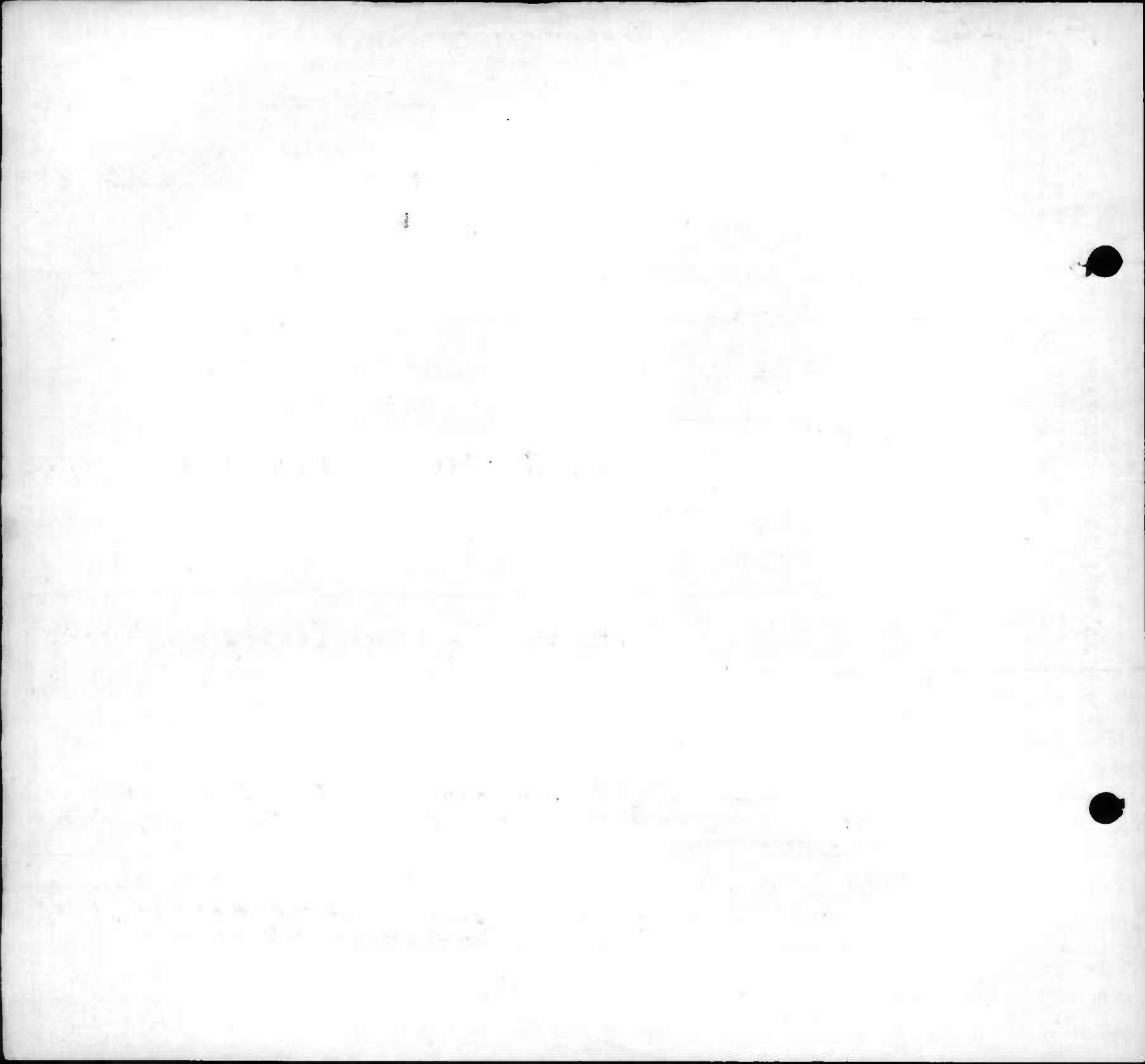
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5718	
BIRTH NO. 67 5718				CERTIFICATE OF DEATH	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) WAITE, DONALD E			JUNE 9, 1967 5:10 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTO., MD 21229			A. STATE MARYLAND 21227 B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1343 POPULAR AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/30/1930	9. AGE (In years) 36	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE-SETTER			10B. KIND OF BUSINESS OR INDUSTRY CALVERT DISTILLERY MASSACHUSETTS		11. BIRTHPLACE (State or foreign country) USA
13. FATHER'S NAME HOMER WAITE			14. MOTHER'S NAME Stella L. Chaplain		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give service) YES			16. SOCIAL SECURITY NO. 213-28-2920		
17. INFORMANT CATON AND WILKENS AVES. 21229 HOSPITAL RECORDS-ST. AGNES HOSPITAL			18. ADDRESS HOSPITAL RECORDS-ST. AGNES HOSPITAL		
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Approximately 50%, second and third degree burns of the body trunk, neck-head and face, and respiratory burn. (B) DUE TO (approval of Medical Examiner, Dr. Hirsch.) (C)		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days		
21A. DATE OF OPERATION 6/6/67 Tracheostomy.			21B. CONDITION FOR WHICH OPERATION WAS PERFORMED Respiratory difficulty.		
21C. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home Garage			21D. WHERE DID INJURY OCCUR? Elkridge, Md. off Hanover Rd.		
21E. TIME OF INJURY (Month) (Day) (Year) (Hour) June 6, 67; 9.15p.m.			21F. HOW DID INJURY OCCUR? gasoline present. While working on the machine with the-		
22. I certify that (I) (this hospital) attended the deceased from JUNE 6, 1967 to JUNE 9, 1967, and that (we) last saw the deceased alive on JUNE 9, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE Thamnoon Penroach			23B. DATE SIGNED 6/9/67		
23C. PHYSICIAN'S NAME (Type) THAMNOON PENROACH			23D. ADDRESS ST. AGNES'S HOSPITAL, BALTO., MD. 21229.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 6/14/67		
24C. NAME OF CEMETERY or CREMATORY West Hatfield			24D. LOCATION (City, town, or county) (State) West Hatfield, Mass.		
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967			25B. NAME OF REGISTRAR Robert E. Gentry		
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.			25D. ADDRESS 5727		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

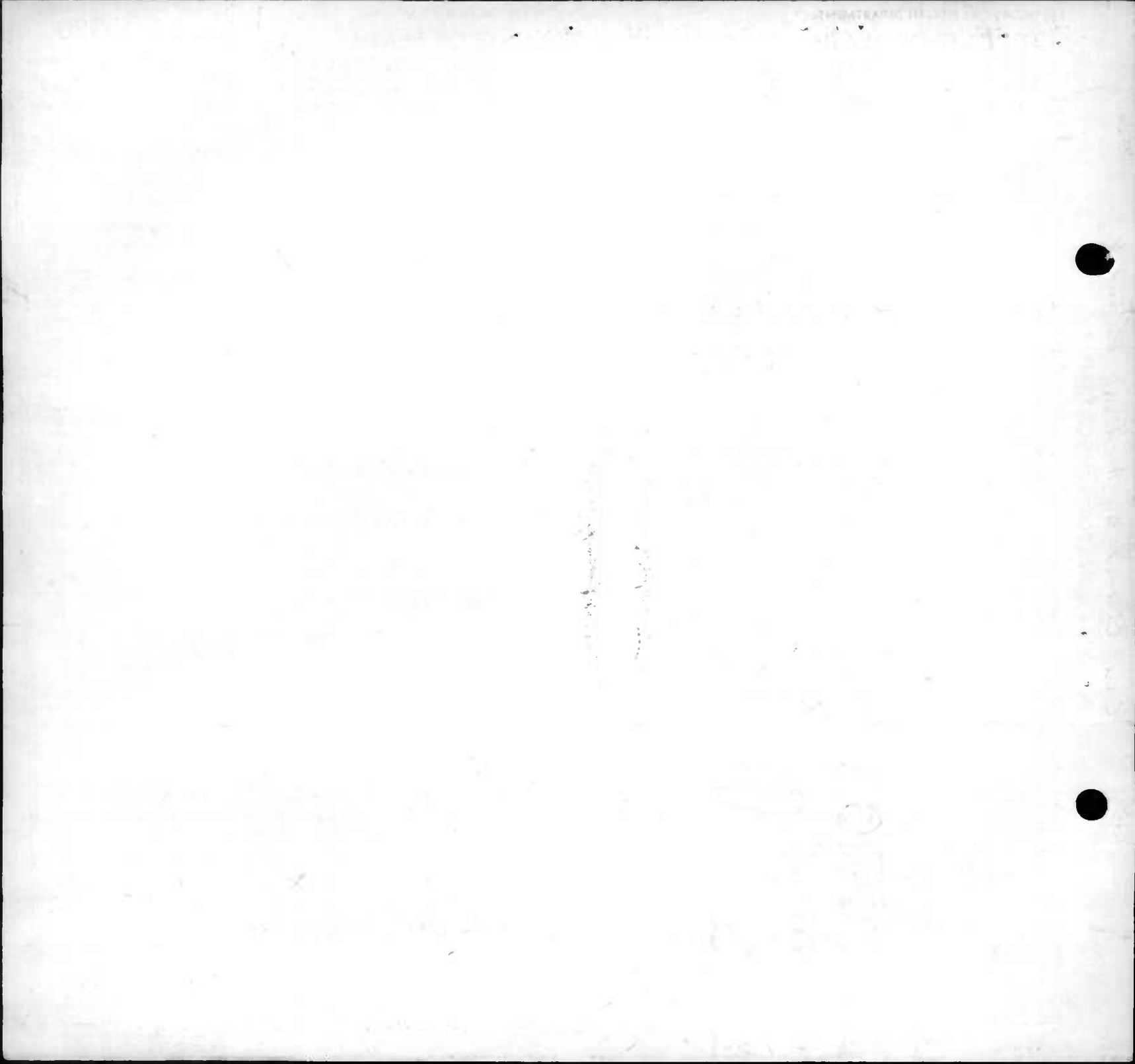
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5719	
<div style="display: flex; justify-content: space-between;"> F-621 BIRTH NO. 67 5719 </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Edgar A. Fraker			2. DATE AND HOUR OF DEATH June 13, 1967 1⁰⁰ A.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 429 E Preston ST 00			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE _____ B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 429 E Preston ST		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug 28, 1960	9. AGE (In years last birthday) 66	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chown Cook & Seal Co			11. BIRTHPLACE (State or foreign country) Penn A		
13. FATHER'S NAME Wilson D Fraker			14. MOTHER'S MAIDEN NAME Ann A Lohman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-09-8067	17. INFORMANT Mrs Viola Fraker	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Diabetes Mellitus at least 10 years			INTERVAL BETWEEN ONSET AND DEATH at least 10 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Heart Failure Congestive 4 years					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Heart Failure		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from MARCH 19 50 to June 13 19 67, that (I) (we) last saw the deceased alive on June 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death.					
23A. SIGNATURE Melvin N. Borden				23B. DATE SIGNED 6/13/67	
23C. PHYSICIAN'S NAME (Type) Melvin N. BORDEN				23D. ADDRESS 5000 BALTIMORE NATIONAL PIKE BALTIMORE, MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/17/67		24C. NAME OF CEMETERY or CREMATORY Price Cem	
24D. LOCATION (City, town, or county) (State) Waynesboro PA					
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR J.F. FINE & Sons	
				ADDRESS Reisterstown Md.	



Case Cleared by Medical Examiner
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5720	
BIRTH NO. 67 5720		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Annie R. Cornell			
2. DATE AND HOUR OF DEATH 6-12-67 at 9:40 AM		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 52-00			
D. STREET ADDRESS (If rural, give location) 112-E. Davis Ave.		8. DATE OF BIRTH 12/23/85 9. AGE (In years last birthday) 82			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME John Hudson		14. MOTHER'S MAIDEN NAME Caroline Mitchell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Cerebrovascular Accident			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) Arteriosclerotic Cardiovascular Disease			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 112-E. Davis Ave.	
21D. TIME OF INJURY (APPROX.) May 18 1967		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell while going to bathroom.	
22. I certify that (I) (this hospital) attended the deceased from May 18 1967 to June 12 1967, that (I) (we) last saw the deceased alive on June 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert C. Blackmon M.D.				23B. DATE SIGNED 6/12/67	
23C. PHYSICIAN'S NAME (Type) Robert C. Blackmon M.D.				23D. ADDRESS Lutheran Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. LOCATION (State)		24F. LOCATION (Address) 2122	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR M. C. Culley Funeral Home	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5721 CERTIFICATE OF DEATH					Registered No. 67 5721				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) MRS. MARY G. TRAINOR					2. DATE AND HOUR OF DEATH JUNE 10, 1967 M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1701 EUTAW PLACE					A. STATE MD.				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
D. STREET ADDRESS (If rural, give location) 1701 EUTAW PLACE					B. COUNTY				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH SEPT. 8, 1880	9. AGE (In years last birthday) 86 YRS.	10. Under 1 Yr. Months: Days:		11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10B. KIND OF BUSINESS OR INDUSTRY BEAUTY SALON OWNER BALTIMORE, MD.			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME JOHN HORSTMAN			14. MOTHER'S MAIDEN NAME ALICE LYNCH						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 215-32-6357			17. INFORMANT MRS. WM. J. HOMBURG			
			ADDRESS 1701 EUTAW PLACE						
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH Hours									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Art. Sclerosis Years									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION None			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from March 1952 to June 10, 1967 , that (I) (we) last saw the deceased alive on May 12, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. Sheldon Eastland M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 6/12/67	
23C. PHYSICIAN'S NAME (Type) J. Sheldon Eastland					23D. ADDRESS M.D. Baltimore, Maryland 21201				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/13/67		24C. NAME OF CEMETERY or CREMATORY CATHEDRAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.			
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR H. W. MEARS & SON 805 N. CALVERT ST.			

June 13, 1957

Mr. J. W. Smith

Dear Sir:

Enclosed please find

one copy of the report

on the subject of the

investigation of the

activities of the various

groups in the area

of the city of New York

and the results of the

Handwritten signature and text

Handwritten signature and text

Very truly yours,

John Doe

cc - Mr. [illegible]

Handwritten signature

Very truly yours,

John Doe

cc - Mr. [illegible]

1
B-520

67 5722

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5722

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

NEWTON P. BANKS (Bankes)

2. DATE AND HOUR PRONOUNCED DEAD

6-10-67 12:40 PM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43 SOUTH BALTIMORE GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1454 Light Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 14, 1925

9. AGE (In years
last birthday)

40 41

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Inspector

10B. KIND OF BUSINESS OR INDUSTRY

Aircraft

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Newton Bankes

14. MOTHER'S MAIDEN NAME

Sarah A. Becker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 2

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Ardis L. Bankes 106 Birkhead St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Craniocerebral injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Laennec's cirrhosis

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Found: Charles & Ostend Streets 23-01

21D. TIME
OF INJURY
APPROX.

(Month) (Day) (Year)

10:00

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Presumably fell

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

6-11-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6 14 67

23C. NAME OF CEMETERY or CREMATORY

U. S. National

23D. LOCATION

(City, town, or county)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

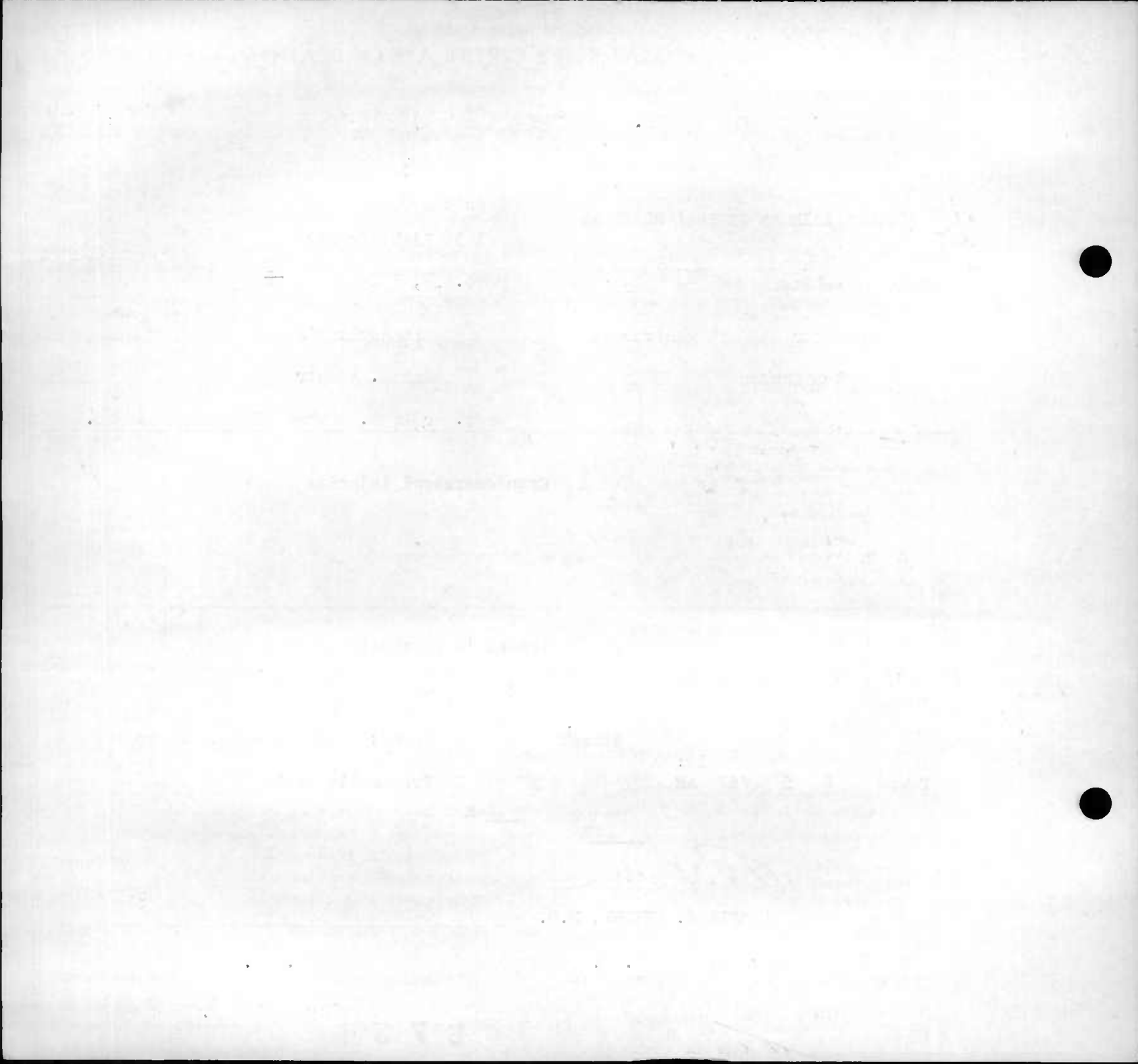
JUN 14 1967

Robert E. Fisher, M.D.

Mc Gully

130 E. Fort Ave

14856-2 7 0 0 0 5 7 3 1



1
D-425

67 5723

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5723

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) HELEN M. DELASHMUTT			2. DATE AND HOUR PRONOUNCED DEAD June 12, 1967 12:50 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1801 Belt Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 24-04 D. STREET ADDRESS (If rural, give location) 1801 Belt Street		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH March 9, 1909	9. AGE (In years last birthday) 58	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME John Jenkins		
14. MOTHER'S MAIDEN NAME Catherine Dailey			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Mr. Howard R. DeLashmutt 1801 Belt St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 10		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?					
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6 16 67		23C. NAME of CEMETERY or CREMATORY Glen Haven	
23D. LOCATION (City, town, or county) (State) Glen Burnie, A. A. Co. Md.					
24A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		24B. NAME OF REGISTRAR Robert E. Feltman		24C. FUNERAL DIRECTOR ADDRESS Mc Gully 130 E. Fort Ave	

5732

WZLH-TV 1300000

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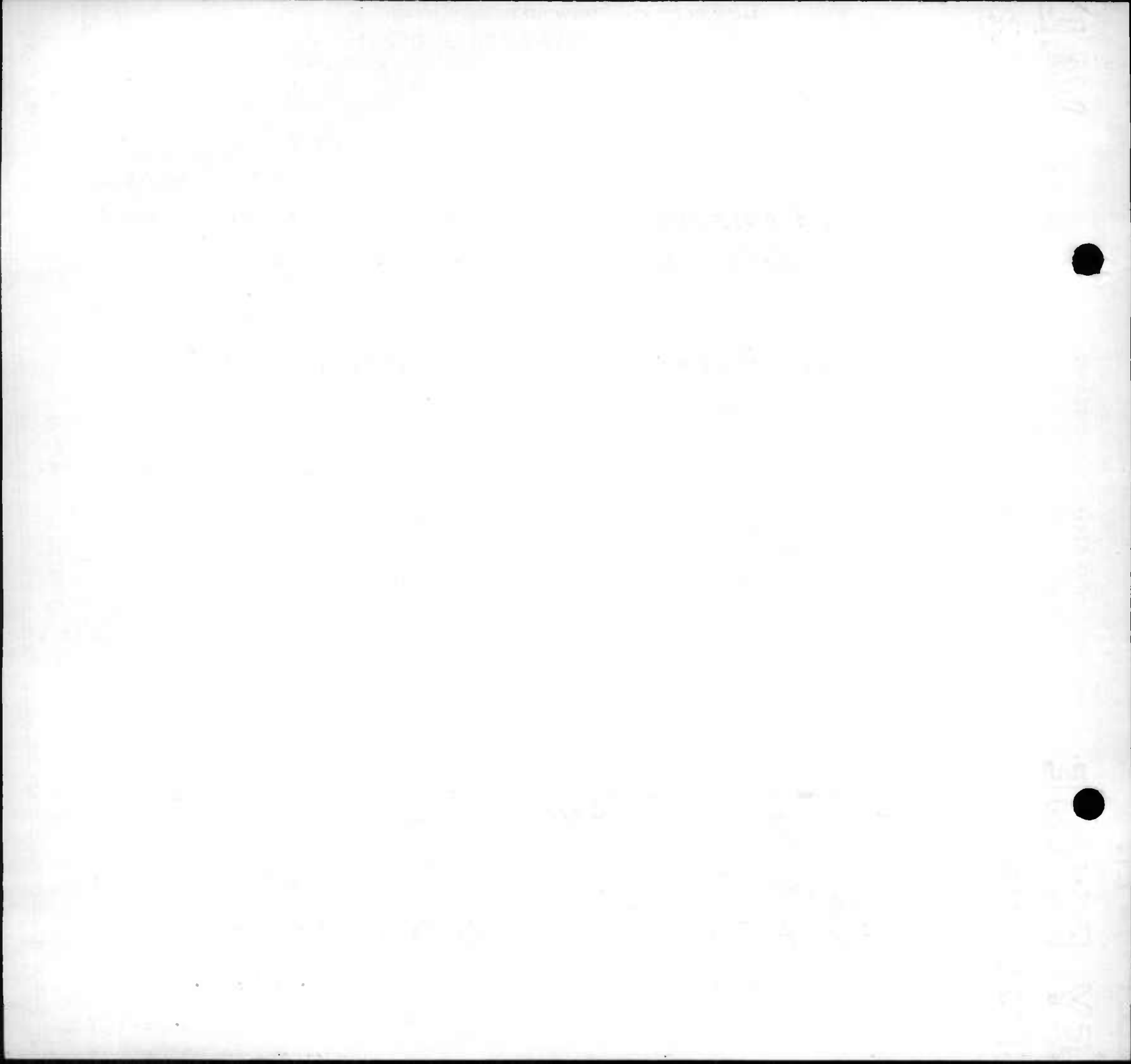
WZLH-TV 1300000

WZLH-TV 1300000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

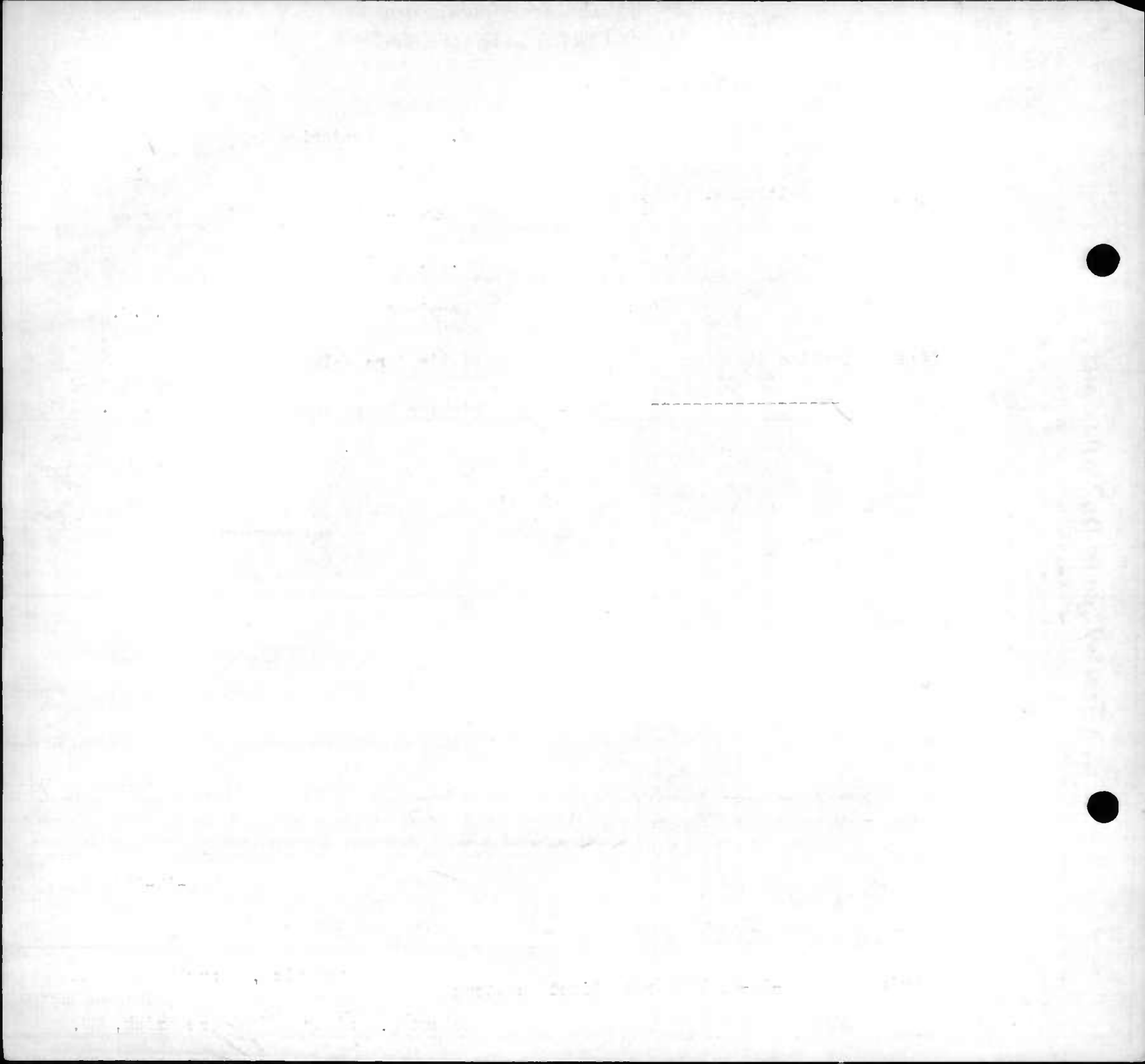
BIRTH NO. 67 5724		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 5724	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Mary E. Grove			2. DATE AND HOUR OF DEATH 6-11-67 12:00 P.M.		
3. PLACE OF DEATH IN BALTIMORE/MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp. (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 24-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21230 D. STREET ADDRESS (If rural, give location) 1155 Riverside Ave.		
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 3-15-93	9. AGE (In years last birthday) 24	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Burns			14. MOTHER'S MAIDEN NAME Anna Zuyk		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Family		ADDRESS Same
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ARTERIO SCLEROTIC CARDIOVASCULAR disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH > 15 years
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			EXCESSIVE OBESITY MARKED		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (at) (this hospital) attended the deceased from 5-31 19 67 to 6-11 19 67 , that (he) (we) last saw the deceased alive on 6-11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gary A. Fleming M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 6-12-67	
23C. PHYSICIAN'S NAME (Type) Gary A. Fleming			23D. ADDRESS M.D. 1213 Light Street		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6 14 67	24C. NAME OF CEMETERY or CREMATORY Pine Grave	24D. LOCATION (City, town, or county) (State) Mt. Airy, Md.		
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR Mc Gully		ADDRESS 130 E. Fort Av



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5725</u>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>67 5725</u> CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Helen Stauffer Ross - Walker</u>			2. DATE AND HOUR OF DEATH <u>6/12/67 - 4:48 A.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>00 500 Somerset Road</u> <u>Baltimore, Maryland 21210</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Frederick Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Frederick, Maryland</u> D. STREET ADDRESS (If rural, give location) <u>Formerly - 104 West College Terrace</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Twice widowed</u>	8. DATE OF BIRTH <u>Dec. 2, 1877</u>	9. AGE (in years last birthday) <u>89</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>David Valentine Stauffer</u>			14. MOTHER'S MAIDEN NAME <u>Willie Anna Walker</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-44-4044</u>	17. INFORMANT <u>Catharine Ross Baker</u>		ADDRESS <u>500 Somerset Road</u> <u>Baltimore, Md. 21210</u>
18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>C.V.A.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>arterio-sclerosis cerebral.</u>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>64 days</u> <u>10 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 56</u> to <u>June 19 67</u> , that (I) was last saw the deceased alive on <u>June 10 19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Palmer F. E. Williams</u> M.D.				23B. DATE SIGNED <u>6-12-1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>PALMER F. E. Williams</u> M.D.				23D. ADDRESS <u>Garage Mills. Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-14-1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mount Olivet Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 14 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Dailey & Son</u>		25C. FUNERAL DIRECTOR <u>Robert E. Dailey & Son</u> ADDRESS <u>Frederick, Md.</u>	



1
H-200

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 5726

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5726

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CHARLES W. HIGGS				2. DATE AND HOUR PRONOUNCED DEAD 6-10-67 8:00 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITAL - DOA				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - Dundalk D. STREET ADDRESS (If rural, give location) 1908 Crafton Road 21222			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Nov. 26, 1898		9. AGE (In years last birthday) 68		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Open Hearth-Retired		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Higgs			14. MOTHER'S MAIDEN NAME Cora Hanson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-6409A		17. INFORMANT (Daughter) Mrs. Jean Timbs, 3410 Yardley Dr. Dundalk,			
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-11-67							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/14/67		23C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park		23D. LOCATION (City, town, or county) (State) Dorsey, Maryland	
24A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		24B. NAME OF REGISTRAR Robert E. Farley		24C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.			

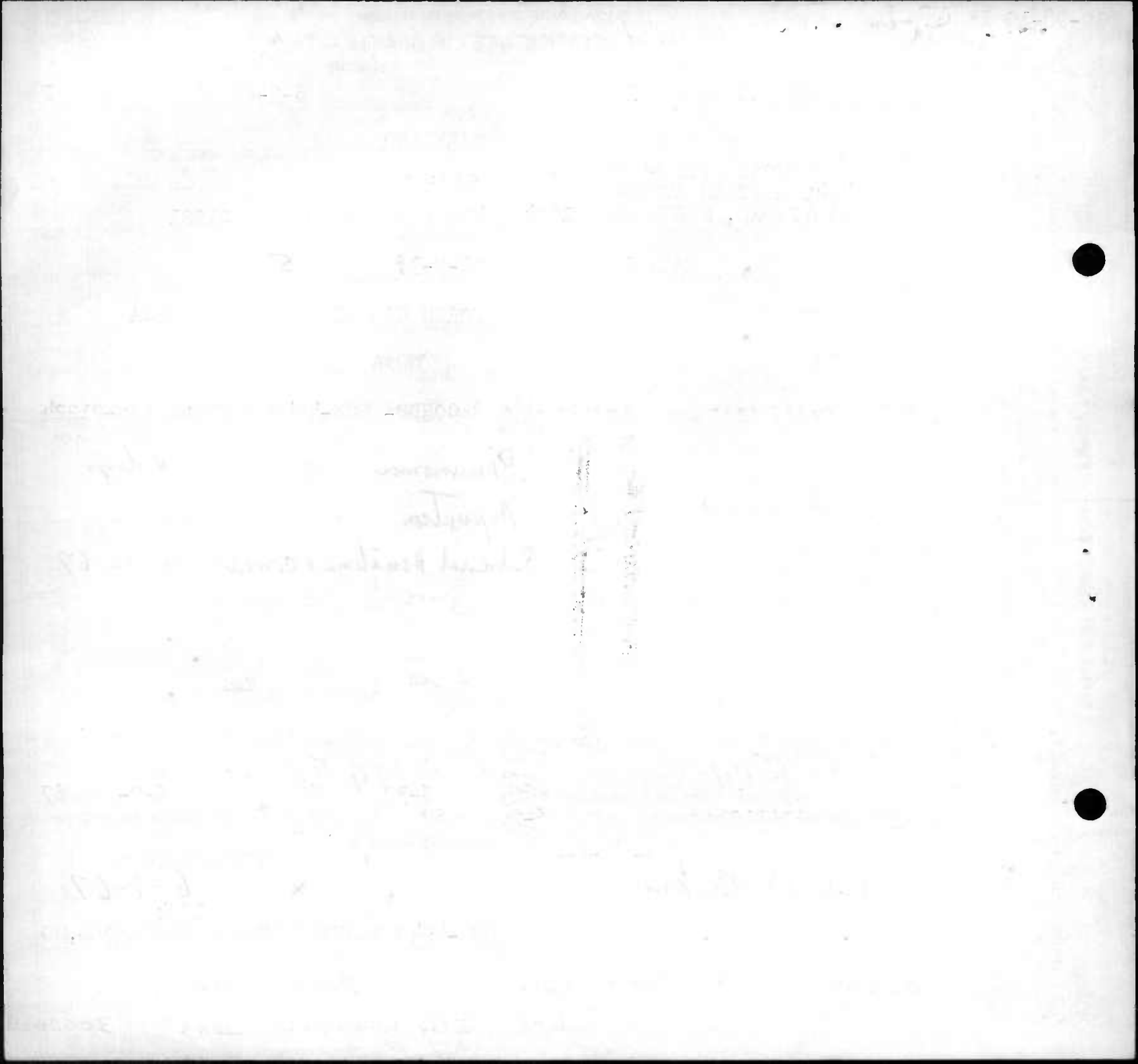
WILEY FOREST

39-98-10 1B

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

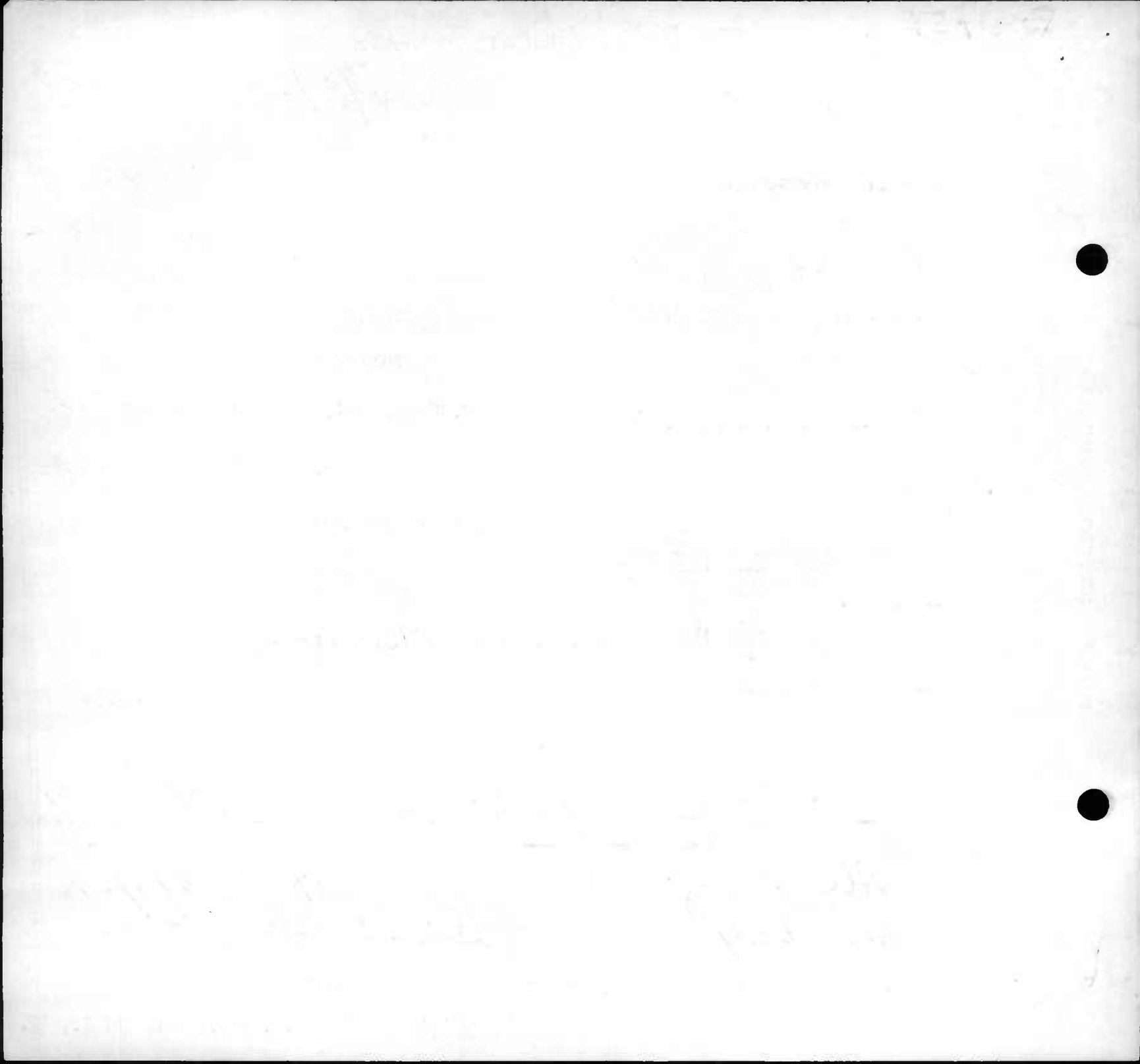
C-600 67 5727		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5727	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				JOE ALLEN CURRIE	
2. DATE AND HOUR OF DEATH		6-9-67 10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
BALTIMORE CITY HOSPITALS		MARYLAND			
4940 EASTERN AVENUE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
BALTIMORE, MARYLAND 21224		ESSEX 53-00			
D. STREET ADDRESS (If rural, give location)		420 EASTERN BLVD #21221			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
MALE	WHITE	MARRIED	11-7-34	36	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY?		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
JOSEPH		NORA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES 1951-1956		245-38-5888		RECORDS BCH-4940 EASTERN AVE-21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Pneumonia		4 days	
ANTECEDENT CAUSES		Aspiration			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Subdural Hematoma + coma		5-30-67	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Home		420 EASTERN B/40 53-00	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
5-About 30-1967-?		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		Probably Fell at home.	
22. I certify that (I) (this hospital) attended the deceased from 5-30 19 67 to 6-9 19 67, that (I) (we) last saw the deceased alive on 6-9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Charles B. Beckman				6-9-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DR. CHARLES B. BECKMAN		BCH-4940 EASTERN AVENUE *BALTIMORE, MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		6/13/67		BALTO. NATL.	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
BALTO. MD.		JUN 14 1967		Robert E. Finkbeiner	
25A. DATE REC'D BY HEALTH DEPT.		25C. FUNERAL DIRECTOR		ADDRESS	
		J.G. CONNELLY SONS		300 MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

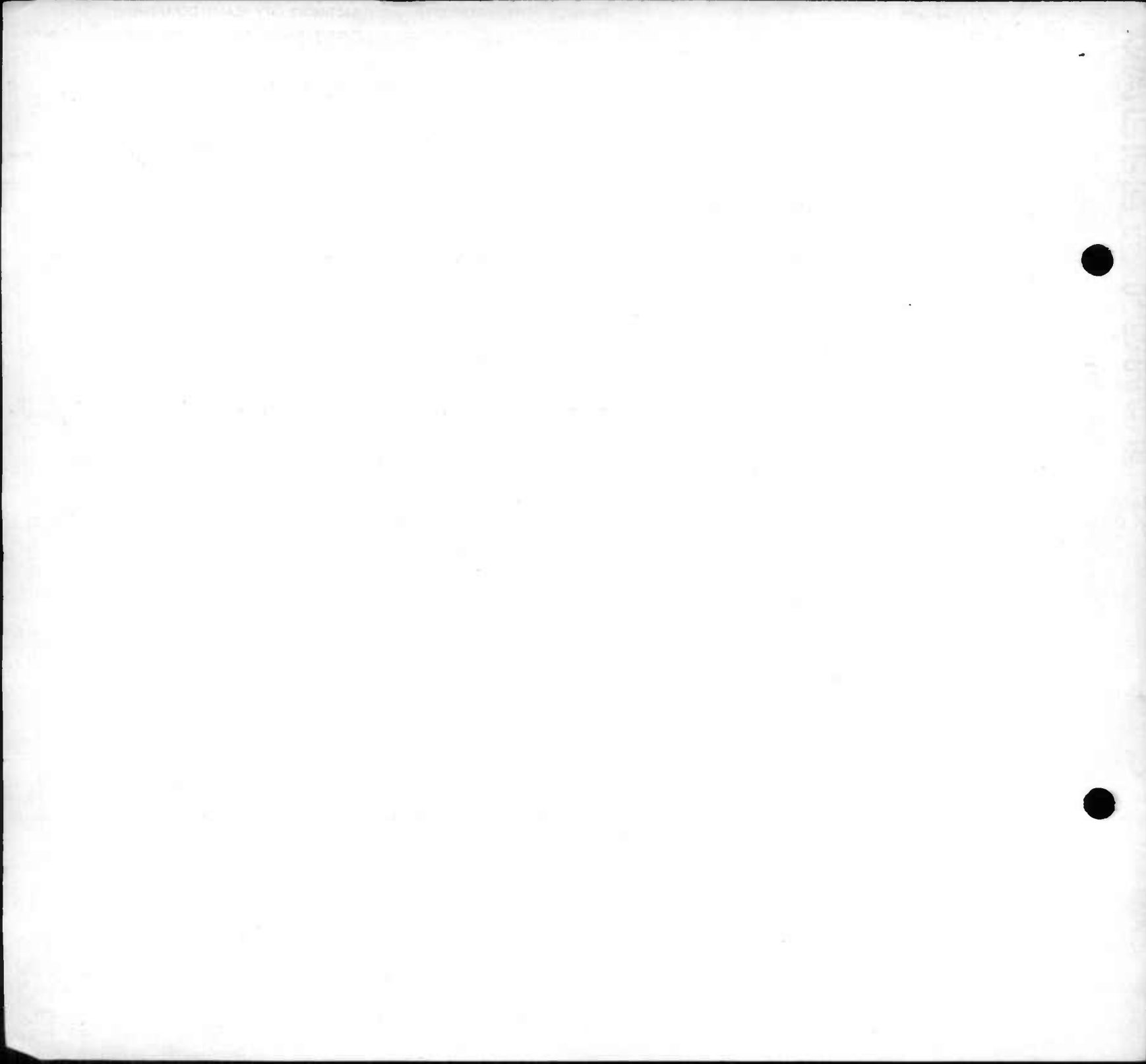
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5728	
67 5728 CERTIFICATE OF DEATH					
BIRTH NO. 51		M.E. CASE NO.		2. DATE AND HOUR OF DEATH 6/9/67 12:05 P.M.	
1. NAME OF DECEASED (Type or Print) RAY BLUMFARB					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE 42		A. STATE MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 1513			
		D. STREET ADDRESS (If rural, give location) 4333 PIMLICO ROAD			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH	9. AGE (In years last birthday) 76	10. If Under 1 Yr. Months Days 10. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME ISAAC RANKIN		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS MR. REUBEN WALL, 5434 NELSON AVENUE #15	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Cerebrovascular Accident DUE TO (B) ASCVD + HCLVD DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 30 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/13 19 67 to 6/9/ 19 67, that (I) (we) last saw the deceased alive on 6/9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Abe Levy		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/9/67	
23C. PHYSICIAN'S NAME (Type) Abe Levy		23D. ADDRESS Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION		24E. CITY, town, or county		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
		SOL LEVINSON & BROS. INC., 6010 REIST., RD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5729	
<p>BIRTH NO. 5-455</p> <p>M.E. CASE NO. 67 5729</p> <p>1. NAME OF DECEASED (Type or Print) NATHAN (NAT) SCHULMAN</p>		<p>2. DATE AND HOUR OF DEATH JUNE 9, 1967 1 5 A. M.</p>			
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>00 6066 GREEN MEADOW PARKWAY</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MARYLAND</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE</p> <p>D. STREET ADDRESS (If rural, give location) 6066 GREEN MEADOW PARKWAY</p>			
<p>5. SEX MALE</p>	<p>6. RACE WHITE</p>	<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED</p>	<p>8. DATE OF BIRTH 12/13/1891</p>	<p>9. AGE (In years last birthday) 75</p>	<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY SALESMAN</p>		<p>11. BIRTHPLACE (State or foreign country) NEW YORK CITY</p>	
<p>13. FATHER'S NAME LOUIS SCHULMAN</p>			<p>14. MOTHER'S MAIDEN NAME ESTHER RUBIN</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>		<p>16. SOCIAL SECURITY NO. 117-05-1459</p>		<p>17. INFORMANT ADDRESS MRS. JESSIE SCHULMAN, 6066 GREEN MEADOW PKWY.</p>	
<p>18. CAUSE OF DEATH</p> <p>420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>19A. DATE OF OPERATION NO</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED m</p>		<p>20A. AUTOPSY? (Yes or No) no</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from Jan 19 60 to June 9 19 67, that (I) (we) last saw the deceased alive on June 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE Maurice Feldman M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p>				<p>23B. DATE SIGNED 6/9/67</p>	
<p>23C. PHYSICIAN'S NAME (Type) DR. MAURICE FELDMAN M.D.</p>				<p>23D. ADDRESS 6610 CROSS COUNTRY BLVD.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p>		<p>24B. DATE 6/11/67</p>		<p>24C. NAME OF CEMETERY OR CREMATORY SHAAREI ZION</p>	
<p>24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND</p>		<p>25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967</p>			
<p>25B. NAME OF REGISTRAR Robert E. [Signature]</p>		<p>25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REIST., RD.</p>			

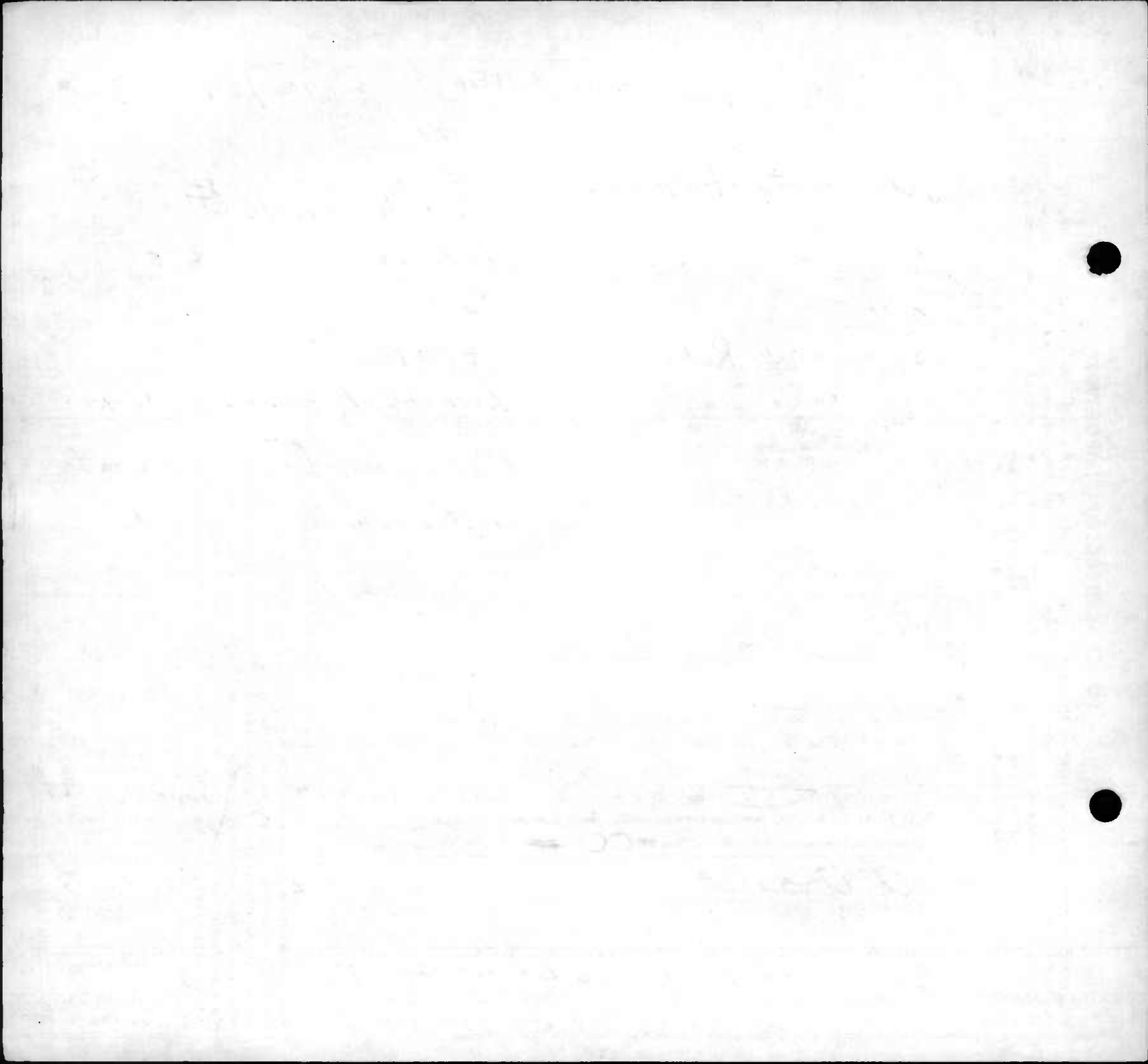


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH											
BIRTH NO. <u>10-26225</u> <u>67</u> <u>5730</u>				Registered No. <u>67</u> <u>5730</u>							
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <u>Eric Ruffin [ERIC RUFFIN]</u>						2. DATE AND HOUR OF DEATH <u>6/12/67</u> <u>932 P</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto</u>					
						D. STREET ADDRESS (If rural, give location) <u>2706 W. Lanvale St.</u>					
5. SEX <u>M</u>		6. RACE <u>N C</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>S</u>		8. DATE OF BIRTH <u>12/17/66</u>		9. AGE (In years last birthday) <u>6</u> <u>5</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>						10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>Bernard Ruffin</u>						14. MOTHER'S MAIDEN NAME <u>Estella Black</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>						16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Bernard Ruffin 2706 W. Lanvale St</u>			
18. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>751.2</u> <u>Meningocele</u>						(A) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) DUE TO <u>Hydrocephalus</u>					
(C) DUE TO											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (If this hospital) attended the deceased from <u>June 10</u> 19 <u>67</u> to <u>June 12</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/12</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>A. Rosenstein</u>						M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>6/12/67</u>	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>6/15/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTO NATIONAL</u>				24D. LOCATION (City, town, or county) (State) <u>BALTO MD</u>			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR <u>A. Rosenstein</u>				25C. FUNERAL DIRECTOR ADDRESS <u>Thompson & Hyatt 638 N. Gilemon St</u>			

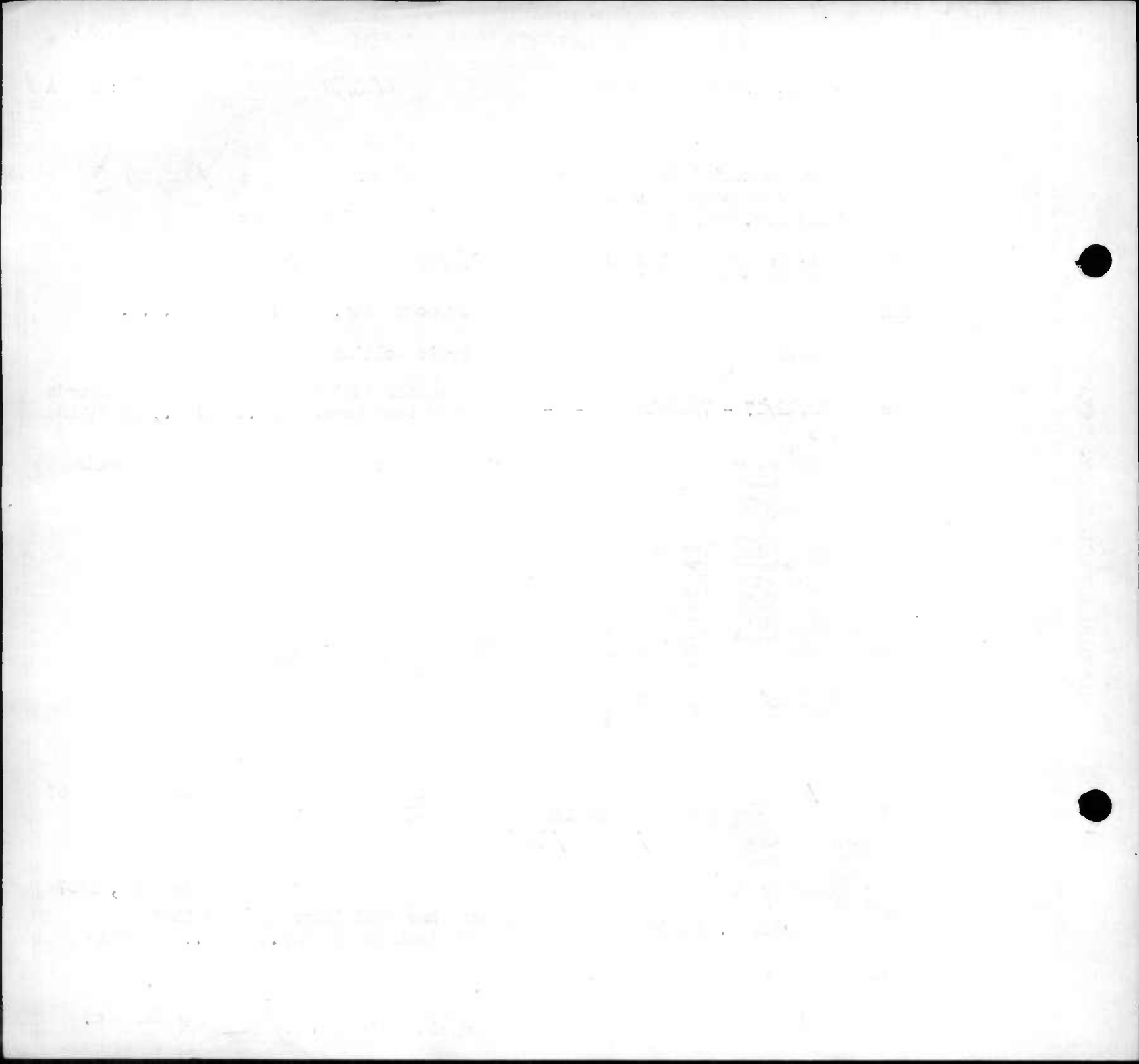
JUN 14 1967



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5731</u>	
BIRTH NO. <u>67 5731</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>6/13/67</u> <u>10:50</u> A.M.			
1. NAME OF DECEASED (Type or Print) <u>WINSLOW, Harrison Clarence</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>27 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1800 Madison Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1/5/95</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pocomoke City, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Clarence Winslow</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Collins</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>12/12/19 - 7/22/19</u>		16. SOCIAL SECURITY NO. <u>224-07-7170</u>		17. INFORMANT ADDRESS <u>Veterans Administration Hospital Records</u> <u>3900 Loch Raven Blvd., Balto., Md 21218</u>	
18. <u>163X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of lung</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>10</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>March 13th</u> 19 <u>67</u> to <u>June 13th</u> 19 <u>67</u> , that <u>(H)</u> (we) last saw the deceased alive on <u>June 13th</u> 19 <u>67</u> and that in <u>(H)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) <u>(H)</u> view the body after death.					
23A. SIGNATURE <u>David N. Marine</u> M.D.				23B. DATE SIGNED <u>June 13, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>DAVID N. MARINE</u> M.D.				23D. ADDRESS <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Blvd., Balto., Md 21218</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/17/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Halls Hill Cem.</u>	
24D. LOCATION <u>Pocomoke City, Md.</u>		24E. LOCATION (City, town, or county)		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 14 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Samuel S. Jones Church, Va.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5732	
CERTIFICATE OF DEATH					
BIRTH NO. 67 5732					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Samuel Waverly Willner		2. DATE AND HOUR OF DEATH 7 June 67 10:55 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hosp		A. STATE Md			
		B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, with RURAL and give township) 23-32			
		D. STREET ADDRESS (If rural, give location) 2852 Brookcroft Dr. Balt. Md			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 3-29-18	9. AGE (In years last birthday) 48	10. AGE (In years last birthday) 48
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Builder		10B. KIND OF BUSINESS OR INDUSTRY Shipbuilding		11. BIRTHPLACE (State or foreign country) Danville, Va.	
13. FATHER'S NAME Joseph Willner		14. MOTHER'S MAIDEN NAME Beatrice Willner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 224-05-5898		17. INFORMANT Mrs. Beatrice E. Willner - 2852 Brookcroft Dr.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Sino Coronary Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO Atherosclerosis - Coronary			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7 June 67 10pm to 7 June 1055pm 67 that (I) (we) last saw the deceased alive on 10:50 June 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D.				23B. DATE SIGNED 7 June 67	
23C. PHYSICIAN'S NAME (Type) [Signature] M.D.				23D. ADDRESS Univ Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/67		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR [Signature]		25D. ADDRESS 3035 W. North Ave.			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

5733

67

5733

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HOWARD S. FOSSETT

2. DATE AND HOUR PRONOUNCED DEAD

6-6-67

5:50 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

610 LENNOX STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

610 Lennox Street 21217

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

May 4, 1911

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

Steel Company

11. BIRTHPLACE (State or foreign country)

Carroll County, Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A

13. FATHER'S NAME

Clarence Fossett

14. MOTHER'S MAIDEN NAME

Mattie Sheppard

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-09-4710

17. INFORMANT

ADDRESS

Mr. Clarence Fossett 2025 N. Smallwood St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

6-7-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/10/67

23C. NAME of CEMETERY or CREMATORY

Johnsville Cemetery

23D. LOCATION

(City, town, or county)

(State)

Johnsville Carroll Co. Md

24A. DATE REC'D BY HEALTH DEPT.

JUN 14 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

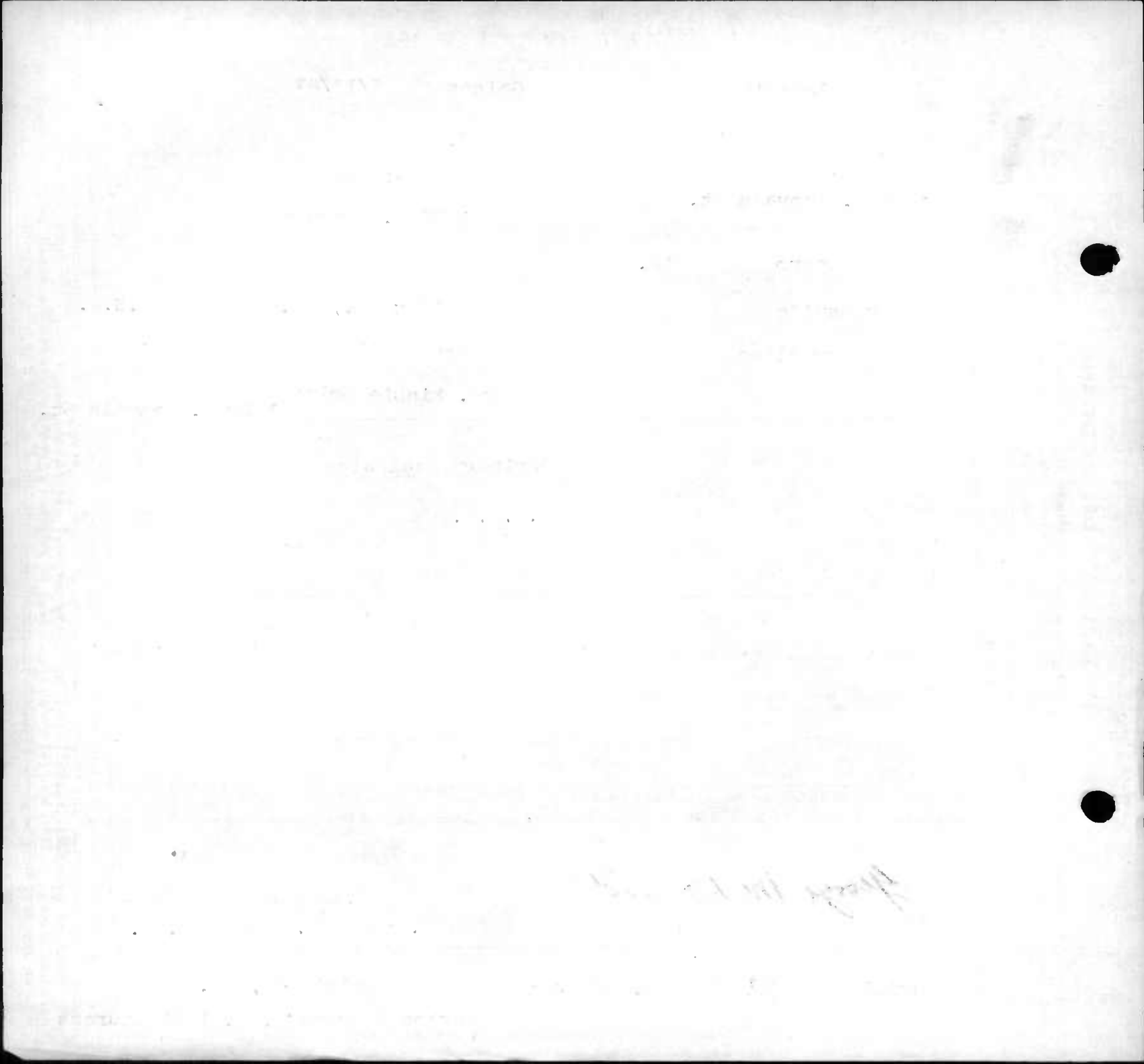
24C. FUNERAL DIRECTOR

Herbert E. Nutter 3035 W. North Ave

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5734		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5734	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Aleathia		2. DATE AND HOUR OF DEATH 6/13/67		M. ?	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1220 W. Lanvale St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 16-01 D. STREET ADDRESS (If rural, give location) 1220 W. Lanvale			
5. SEX Fe	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Wid.	8. DATE OF BIRTH July 5, 1888	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Halifax Co., Va.	
13. FATHER'S NAME Henry Allen		14. MOTHER'S MAIDEN NAME Martha Allen		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-30-0025		17. INFORMANT Mrs. Minnie Holmes ADDRESS 1220 W. Lanvale St.	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Corinary Occlusion DUE TO A.H.C.V.D		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH ?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) None	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from many years 19 to 6/12/67 19		that (I) (we) last saw the deceased alive on June 12, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE George Mc Donald		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/67	
23C. PHYSICIAN'S NAME (Type) George Mc Donald		23D. ADDRESS 844 N. Carey St. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/17/67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Morton & Dyett F. H. 1701 Laurens			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 520		67 5735		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5735	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HOWARD JONES				2. DATE AND HOUR OF DEATH 6-9-67 10 20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 4-02 D. STREET ADDRESS (If rural, give location) 689 West Mulberry St.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 1-22-01	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Jones				14. MOTHER'S MAIDEN NAME Rachel Gibson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT BCM: Records 4940 Eastern Ave. Baltimore, Md.			
18. 334 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cerebral Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pyelonephritis				INTERVAL BETWEEN ONSET AND DEATH > 2 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Yes or No NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that he (this hospital) attended the deceased from 4-28 19 67 to 6-9 19 67 , that he (we) last saw the deceased alive on 6-9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James J. Corkins				M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-9-67	
23C. PHYSICIAN'S NAME (Type) James T. Corkins				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/67		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North ave			



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Main body of handwritten text, appearing to be a list or series of entries, spanning across the middle of the page.

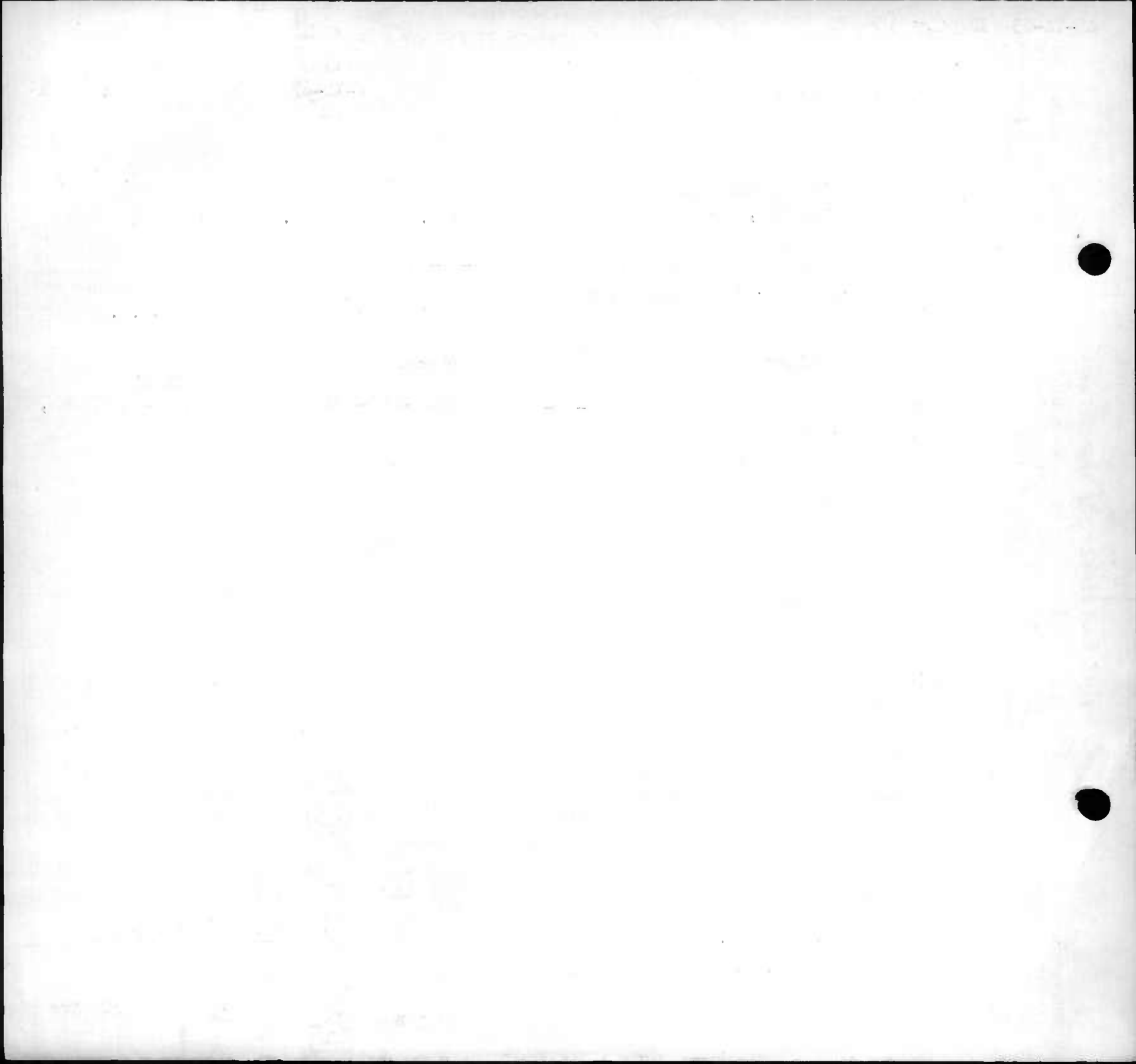
Handwritten text at the bottom right, possibly a signature or a concluding note.

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FUNERAL DIRECTOR: IMPORTANT

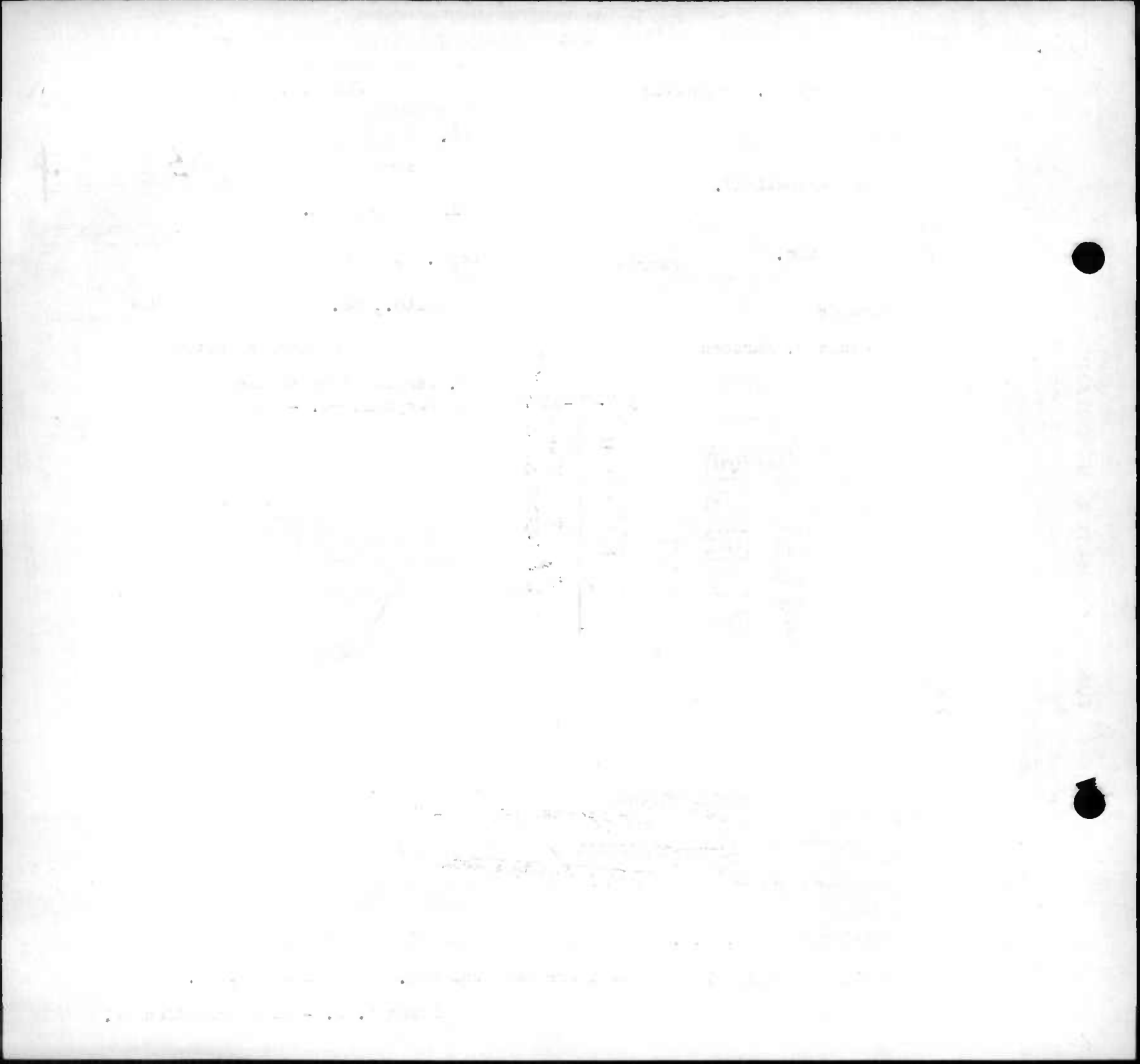
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 5736		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5736	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DAISY LANCE		6-10-67 6:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		MARYLAND BALTIMORE			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
FEMALE		NEGRO		SEPARATED	
8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. CITIZEN OF WHAT COUNTRY?	
5-17-22		45		U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Domestic		Restaurant		South Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Allen Holmes		Rebecca		no	
16. SOCIAL SECURITY NO.		17. INFORMATION		18. ADDRESS	
213-28-3957		RECORDS-BCM-4940 EASTERN AVENUE-BALTIMORE, MD		21224	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Breast aden cancer with widespread metastases	
ANTECEDENT CAUSES		(B) DUE TO		3 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
1963		breast Ca		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/25/67 to 6/10/67, that (I) (we) last saw the deceased alive on 6/10/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Bruce M. Dow		6/10/67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DR. BRUCE M. DOW		BC H 21224 4940 EASTERN AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/14/67		Mt Calvary Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 14 1967		Robert E. Fairbank		Adolphus Halstead	
				ADDRESS 1206 W North Ave	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5737	
BIRTH NO. 67 5737				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Mary E. Rosendale				June 12, 1967 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. (If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 311 Maryland Rd.				A. STATE Ma.	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
				D. STREET ADDRESS (If rural, give location) 311 Maryland Rd.	
5. SEX F	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept. 6, 1888	9. AGE (In years last birthday) 78	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jesse B. Marsden			14. MOTHER'S MAIDEN NAME Catherine Howard		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 307-0-3097B		17. INFORMANT Mr. Ferdinand Rosendale 311 Maryland Rd. - 21229
18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			19. CAUSE OF DEATH Acidosis Severe dehydration Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1967 to June 12 1967 , that (I) (we) lost saw the deceased alive on June 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley Ankudas				23B. DATE SIGNED 6.13.67	
23C. PHYSICIAN'S NAME (Type) Stanley Ankudas, M.D.				23D. ADDRESS 1101 Maiden Choice Lane	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/15/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR Witzke, F. D.		25C. FUNERAL DIRECTOR Witzke, F. D. - 4101 Edmondson Av.	



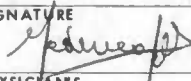
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5738	
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Mary I. Goldsborough </div> <div> 2. DATE AND HOUR OF DEATH June 11, 1967 </div> </div>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 5300 Frederick Ave. </div> <div> (If not in hospital or institution, give street address or location) </div> </div>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5300 Frederick Ave.		
5. SEX F	6. RACE Cauc.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10/22/87	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Isaac R. Long			14. MOTHER'S MAIDEN NAME Rosa M. -----		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-10-7613		17. INFORMANT ADDRESS Mr. Thomas A. Goldsborough 5300 Frederick Ave. - 21229	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (A) DUE TO Cerebral hemorrhage (B) DUE TO Arteriosclerotic C.V. Disease (C) DUE TO </div> <div> INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 10 years </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 4 1967 to June 11 1967, that (I) (we) last saw the deceased alive on June 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John F. Coelahan				23B. DATE SIGNED 6/13/67	
23C. PHYSICIAN'S NAME (Type) John F. Coelahan				23D. ADDRESS 4201 Wilkens Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/67		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Witzke R. D. - 4101 Edmondson Ave.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5739	
BIRTH NO. 67 5739		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JAMES N. HEILE		2. DATE AND HOUR OF DEATH JUNE 12, 1967 5:30 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 29, MARYLAND		A. STATE MARYLAND 21223 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2608 LEHMAN STREET			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 4-1-89	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED -Civ. Engr. State Roads		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH Henry Heile			
14. MOTHER'S MAIDEN NAME Georgianna ELIZABETH (WADE)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES -----			
16. SOCIAL SECURITY NO. 220-44-1829		17. INFORMANT Miss Alice Deering-Homewood Apts.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 153.01 Generalized Metastasis		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Carcinoma of the Colon		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 5, 1967 to JUNE 12, 1967 , that (I) (we) last saw the deceased alive on JUNE 12, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-12-67	
23C. PHYSICIAN'S NAME (Type) FREDERICO POLLICINA		23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/67		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR Alfred E. Sullivan		25C. FUNERAL DIRECTOR Witzke, F. D. - 4101 Diamondson Av.	

JUNE 12, 1963

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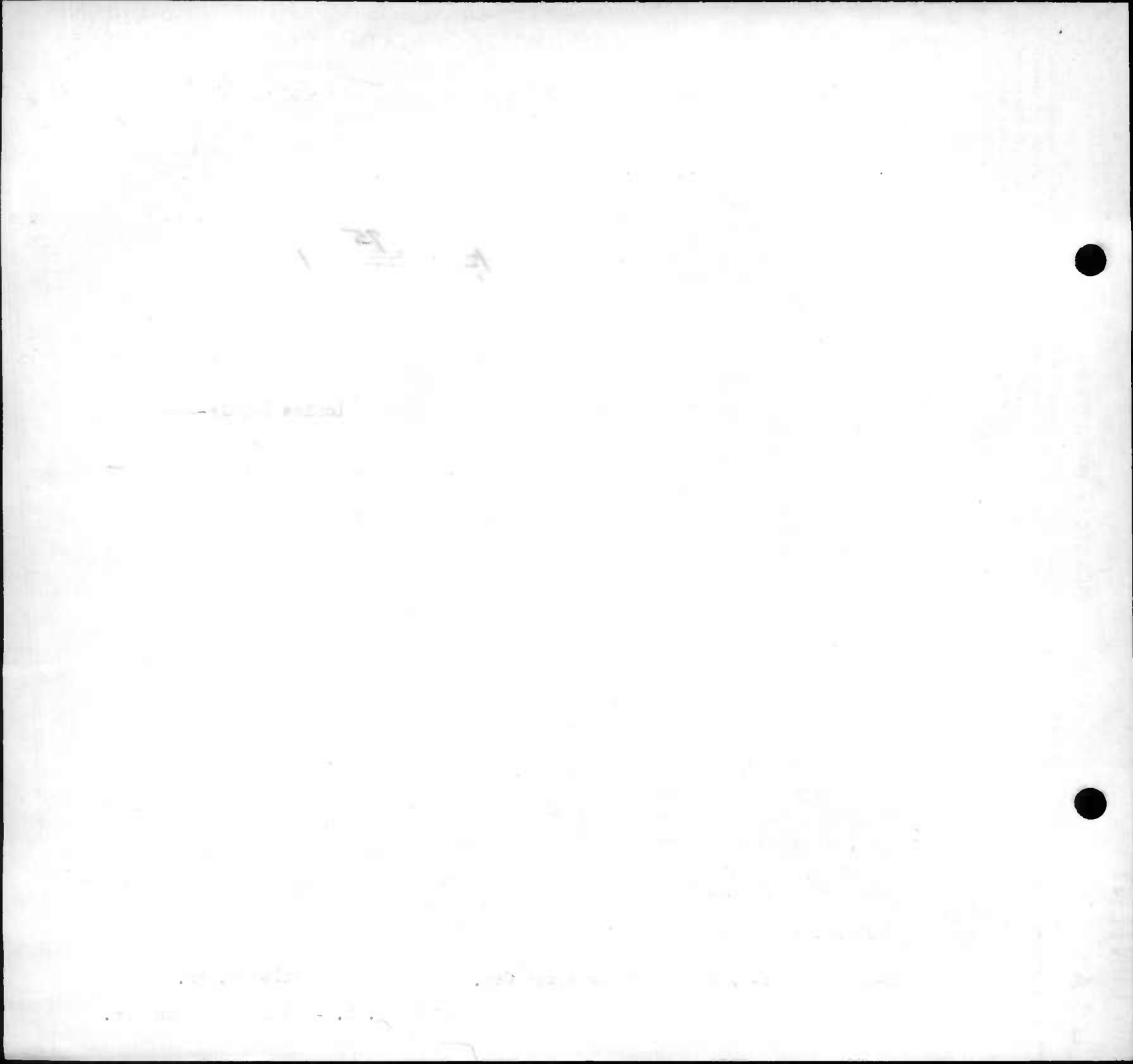
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

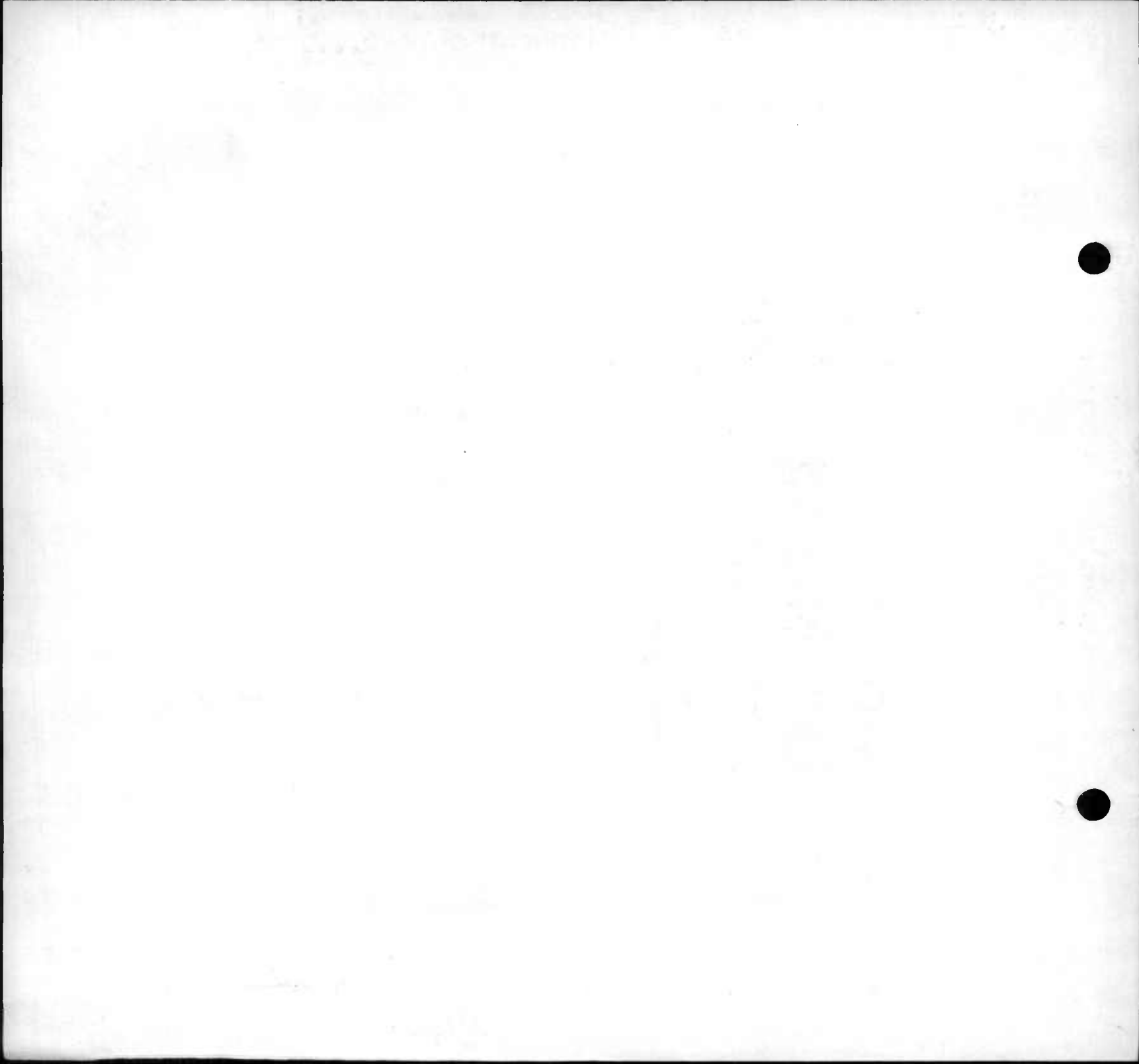
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5740	
67 5740				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Mary AMANDA Haynie	
2. DATE AND HOUR OF DEATH		5/11/67 9 ⁰⁶ P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
University of Maryland Hosp. 38 Lombard & Green St. Baltimore 1, Maryland		Maryland 16-02			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 21228			
D. STREET ADDRESS (If rural, give location)		1504 Edmondson Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	Caucasian	Married - widowed	2/27/35	91	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Spring hill Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Frank P Mc Ginnes		Louise Haynie-Sane		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		JA 058472		Daughter of Hospital Record Louis Haynie-Sane	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) Gastrointestinal Bleeding		3 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Mesenteric Artery Thrombosis			
II		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 6-10 19 67 to 6-11 19 67, that (X) (we) last saw the deceased alive on 6-11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
Stanley L Blum		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		6-11-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
STANLEY L BLUM		M.D. Some AS #3			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		6/15/67		Druid Ridge Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 14 1967		R. E. E. Taylor		Witzke F. D. - 4101 Edmondson Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5741	
BIRTH NO. 67 5741		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Wiggins, Delia		2. DATE AND HOUR OF DEATH June 8th 1967 5:10A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Sinai Hospital of Baltimore FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
6. STREET ADDRESS (If rural, give location) 2101 W Coldspring La (Bar Willba Nursing Home)		7. SEX F		8. RACE N	
9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M		10. DATE OF BIRTH 2/2/94		11. AGE (In years last birthday) 73	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		13. KIND OF BUSINESS OR INDUSTRY		14. BIRTHPLACE (State or foreign country) Va.	
15. FATHER'S NAME Sammy Massenberg		16. MOTHER'S MAIDEN NAME Delia		17. CITIZEN OF WHAT COUNTRY?	
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		19. SOCIAL SECURITY NO.		20. INFORMANT Glenn J. Sam Chinn Jr.	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I		22. CAUSE OF DEATH (A) Congestive Heart Failure (B) ASCVD (C)		23. INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
24. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Old CVA		26. UNKNOWN	
27. DATE OF OPERATION		28. CONDITION FOR WHICH OPERATION WAS PERFORMED		29. AUTOPSY? (Yes or No)	
30. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
33. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		34. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		35. HOW DID INJURY OCCUR?	
36. I certify that (I) (this hospital) attended the deceased from 5/31 19 67 to 6/8 19 67 , that (I) (we) last saw the deceased alive on 6/8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
37. SIGNATURE William Cieplinski				38. DATE SIGNED 6/8/67	
39. PHYSICIAN'S NAME (Type) William Cieplinski				40. ADDRESS Sinai Hospital of Baltimore	
41. BURIAL CREMATION, REMOVAL (Specify) Burial June 13/67		42. NAME OF CEMETERY or CREMATORY McCalumy Cem		43. LOCATION (City, town, or county) (State) Baltimore City, Md.	
44. DATE REC'D BY HEALTH DEPT. JUN 14 1967		45. NAME OF REGISTRAR Robert E. Jackson		46. FUNERAL DIRECTOR Metron E. Elicker	
				47. ADDRESS 1129 N. Caroline	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5742		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5742	
M.E. CASE NO. 1		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Young, Lillian		2. DATE AND HOUR OF DEATH June 7, 1967		9:30 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City 7-05 D. STREET ADDRESS (If rural, give location) 814 Rutland Avenue			
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-28-99	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME John Mollock		14. MOTHER'S MAIDEN NAME Julia Ennalls	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Chart, J.H.H.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 447.01 Probable pulmonary embolus Venous insufficiency of lower extremities		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 hours years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Arteriosclerosis		Years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from June 7 1967 to June 7 1967, that (I) (we) last saw the deceased alive on June 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edgar W. Hull				23B. DATE SIGNED June 7, 1967	
23C. PHYSICIAN'S NAME (Type) Edgar W. Hull				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial June 9/67		24B. DATE June 9/67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem Park	
24D. LOCATION (City, town, or county) (State) Arbutus Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR Gladys E. Taylor	
25C. FUNERAL DIRECTOR		25D. ADDRESS 11297, Carlisle			

59

67 5743

BALTIMORE CITY HEALTH DEPARTMENT

67 5743

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANNIE

COOK

2. DATE AND HOUR PRONOUNCED DEAD

June 5, 1967 11:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 2549 Kirk Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2549 Kirk Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

April 26, 1911

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Winfield Hurst

14. MOTHER'S MAIDEN NAME

Cecilia

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Nancy Loyal 2549 Kirk Ave.

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic and Hypertensive
Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type) Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/6/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Winnipeg

Winnipeg
Manitoba

Winnipeg
Manitoba
Canada

Winnipeg
Manitoba
Canada

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5744				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5744	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) ETHEL ADAMS				6-10-67 8:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital				A. STATE MD B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BOWTINQUE			
				D. STREET ADDRESS (If rural, give location) 1712 BEAUMONT AVE			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 9-11-11	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME FREDERICK KEENE				14. MOTHER'S MAIDEN NAME JESSIE FISHER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS SISTER		
18. 053.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septicemia, probably Cl. Welchii (anally bacteriologic confirmation)				CAUSE OF DEATH (A) DU TO (B) DU TO (C)			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Nutritional anorexia & hemorrhage + jaundice							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-13-67 19 to 6-10 19 67 , that (I) (we) last saw the deceased alive on 6-10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Earlbert J. Ferguson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-10-67	
23C. PHYSICIAN'S NAME (Type) EDUARD G. GORDON JR.				23D. ADDRESS UNION MEMORIAL HOSP			
24A. BURIAL, CREMATION, REMOVAL (Specify) Buried		24B. DATE June 14/67		24C. NAME OF CEMETERY or CREMATORY Oldfield Cemetery		24D. LOCATION (City, town, or county) (State) Bowling Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR Robert E. Ferguson		25C. FUNERAL DIRECTOR William E. Erickson		ADDRESS 11297 Curtis	

4-10-12

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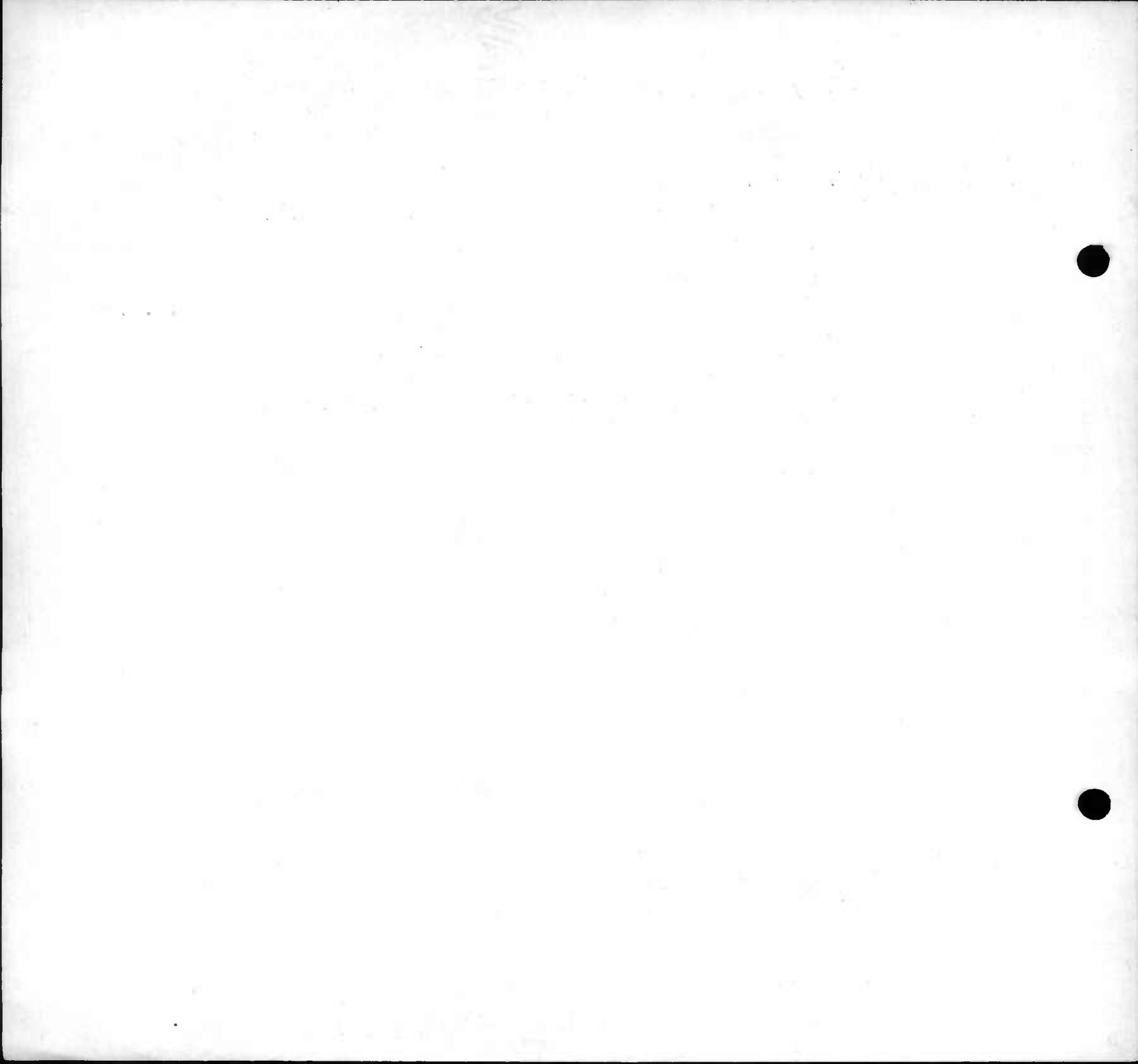
11-11-12

11-11-12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5745					CERTIFICATE OF DEATH		Registered No. 67 5745		
1. NAME OF DECEASED (Type or Print) SAMUEL L. Abrahams					2. DATE AND HOUR OF DEATH 6-11-67				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 26-08				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Gould Conv. Home Baltimore, Md.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 123 S. Highland Avenue				
5. SEX M	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 1/16/83	9. AGE (In years lost birthday) 84	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Diver				10B. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Abrahams				14. MOTHER'S MAIDEN NAME Pauline Levy					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-12-4982		17. INFORMANT ADDRESS Mrs. Abrahams			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) Anterograde C.V. Disease					INTERVAL BETWEEN ONSET AND DEATH 5-10/15				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 7 AM 19 46 to JUNE 11 19 67 , that (I) (we) last saw the deceased alive on 6/7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Benjamin Hyghstein					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/4/67		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/67		24C. NAME OF CEMETERY or CREMATORY London Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Joseph P. Zannino		ADDRESS 263 S. Conkling			



BIRTH NO.

67 5746

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5746

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH FORSYTHE Sr.

2. DATE AND HOUR PRONOUNCED DEAD

6-12-67

6:20 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MARYLAND GENERAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3900 E. Pratt Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

11/30/25

9. AGE (In years
lost birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Crane Operator

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry Forsythe

14. MOTHER'S MAIDEN NAME

Annie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.II

16. SOCIAL
SECURITY NO.

213-10-1315

17. INFORMANT

Mrs. Forsythe

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Multiple traumatic injuries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Ore Pier

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Ore Pier - Bethlehem Steel

Corp. - Sparrows Point Plant, Md.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6 12 '67 4:29 PM

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK21F. HOW DID INJURY OCCUR? Was loading ore ship -
track gave way and cab of crane fell on
him

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-13-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/16/67

23C. NAME OF CEMETERY or CREMATORY

Oaklawn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 14 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Joseph N. Bannino

ADDRESS

203 S. Conkling

WALTER HIGGINS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5747	
BIRTH NO. 67-11272 67 5747		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Girl Erwin (Michelle)		2. DATE AND HOUR OF DEATH 6-9-67 1:30 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		20-04	
				D. STREET ADDRESS (If rural, give location) 2233 W. Baltimore St.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6/8/67	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Baltimore Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Michael Erwin		14. MOTHER'S MAIDEN NAME Joann Evans		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Michael Erwin		ADDRESS 2233 W. Baltimore St.					
18. 760.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH Subarachnoid hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-8-67 19 to 6-9-67 19 that (I) (we) last saw the deceased alive on 6-9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Perry L. Shelton				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-9-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Joseph R. Russ		ADDRESS 2222 W. North Ave. Baltimore, Md.	

James M. Smith

1850

1850-1851

James M. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5748		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5748	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FRANKLIN, JESSE JAMES		2. DATE AND HOUR OF DEATH 6/6/67 5:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND 730 ASHBURTON ST.		A. STATE MARYLAND B. COUNTY 20-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 241 EDMONDSON AVE.			
5. SEX M	6. RACE C	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED, <u>SEPARATED</u> (Specify) DIVORCED	8. DATE OF BIRTH 12/27/90	9. AGE (In years last birthday) 76	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ALMA RUTH COFIELD SAME.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260X I DIABETIC ACIDOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 9-20-6 CERTIFICATION APPROVED MEDICAL EXAMINER II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH DIABETIC ACIDOSIS ARTERIO SCLEROTIC HYPER TENSIVE CARDIO VASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/12/1967 to 6/6/1967, that (I) (we) last saw the deceased alive on 6/6/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE V. Biswanath Pillai				23B. DATE SIGNED 6/6/67	
23C. PHYSICIAN'S NAME (Type) V. BISWANATH PILLAI				23D. ADDRESS M.D. 730 ASHBURTON STREET	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/9/67		24C. NAME OF CEMETERY OR CREMATORY Western Star Cemetery Catonsville Md.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR Joseph A. Rues	
25C. FUNERAL DIRECTOR'S ADDRESS 2222 N. Northgate Baltimore, Md.					

6/1/61

RECEIVED

10/1/61

301 E. BROADWAY

10/1/61

20

RECEIVED

10/1/61

10/1/61

10/1/61

10/1/61

10/1/61

10/1/61

10/1/61

10/1/61

10/1/61

10/1/61

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5749	
BIRTH NO. 67 5749				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) John A Johnson		2. DATE AND HOUR OF DEATH 8 June 67 8 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION MD. Gen'l Hosp		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.			
		D. STREET ADDRESS (If rural, give location) 20 N. Monastery Rd.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12-10-89	9. AGE (In years last birthday) 77	10. Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired - ?		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME STANSBURY Johnson		14. MOTHER'S MAIDEN NAME Matilda ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-10-6161		17. INFORMANT Son on addn.	
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO ASCVD			
		(B) DUE TO Cerebral			
		(C) Cerebral infarction			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-7-67 to 6-8-67 19 67 , that (I) (we) last saw the deceased alive on 6-8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 8 June 67	
23C. PHYSICIAN'S NAME (Type) DEAN H GRIFFIN				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Westport (Baltimore) Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Joseph H. Ryes 2222 N. North Ave. Baltimore, Md.	

John A. Johnson
June 21

Mr. Carl Hays
204 N. West 1st St.
St. Paul, Minn.

My Dear Mr. Hays:
I have just received your letter of the 15th inst. regarding the matter of the St. Paul, Minn. case.

Very truly yours,
John A. Johnson

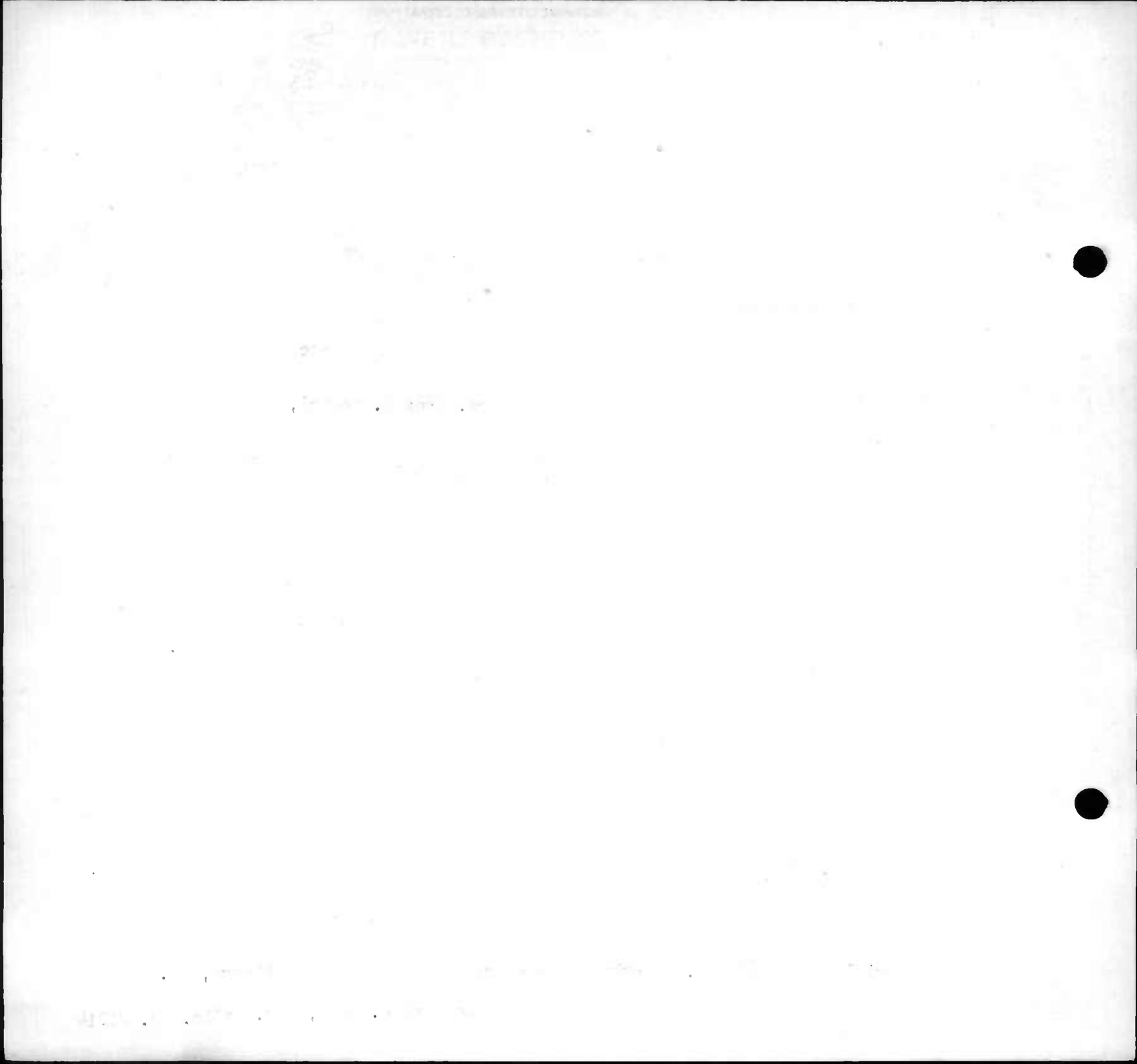
6-8
6-7
6-6
6-5
6-4
6-3
6-2
6-1

John A. Johnson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5750	
67 5750		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ernest N. Rommel		2. DATE AND HOUR OF DEATH June 13 1967 1:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3016 Olisa Ave		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21214 2703 D. STREET ADDRESS (If rural, give location) 3016 Olisa Ave			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M.	8. DATE OF BIRTH September 6 1894 AGE (In years most birthday) 72		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman G & F Co		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frederick Rommel			14. MOTHER'S MAIDEN NAME Louise Benecke		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 212053441-A		17. INFORMANT ADDRESS Mrs. Emma C. Rommel, 3016 Olisa Ave	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Squamous cell carcinoma Pharynx ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8-10-1966		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Pharynx		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-1-66 19 to June 6 19 67 , that (I) (we) last saw the deceased alive on June 6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sebastian Russo M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 6-13-67	
23C. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO		23D. ADDRESS 5017 HANFORD Road Balto 21214			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/67.		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR 675750		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5751BIRTH NO. 67 5751

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HENRY

NAGLE

2. DATE AND HOUR PRONOUNCED DEAD

June 9, 1967

4:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3402 Ravenwood Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3402 Ravenwood Avenue

5. SEX

Male

6. RACE

White

7. MARRIED; NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

11/9/1874

9. AGE (In years
last birthday)

92

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Molder

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Freeland, Pa.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jacob Nagle

14. MOTHER'S MAIDEN NAME

Un Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Botman & Rosenstock F. H. Co. Pa.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

6/8/67

23A. BURIAL CREMATION;
REMOVAL (Specify)

Burial

23B. DATE

6/12/67

23C. NAME OF CEMETERY OR CREMATORY

Vine Street Cem.

23D. LOCATION

(City, town, or county)

(State)

Hazelton, Pa.

24A. DATE REC'D BY HEALTH DEPT.

JUN 14 1967

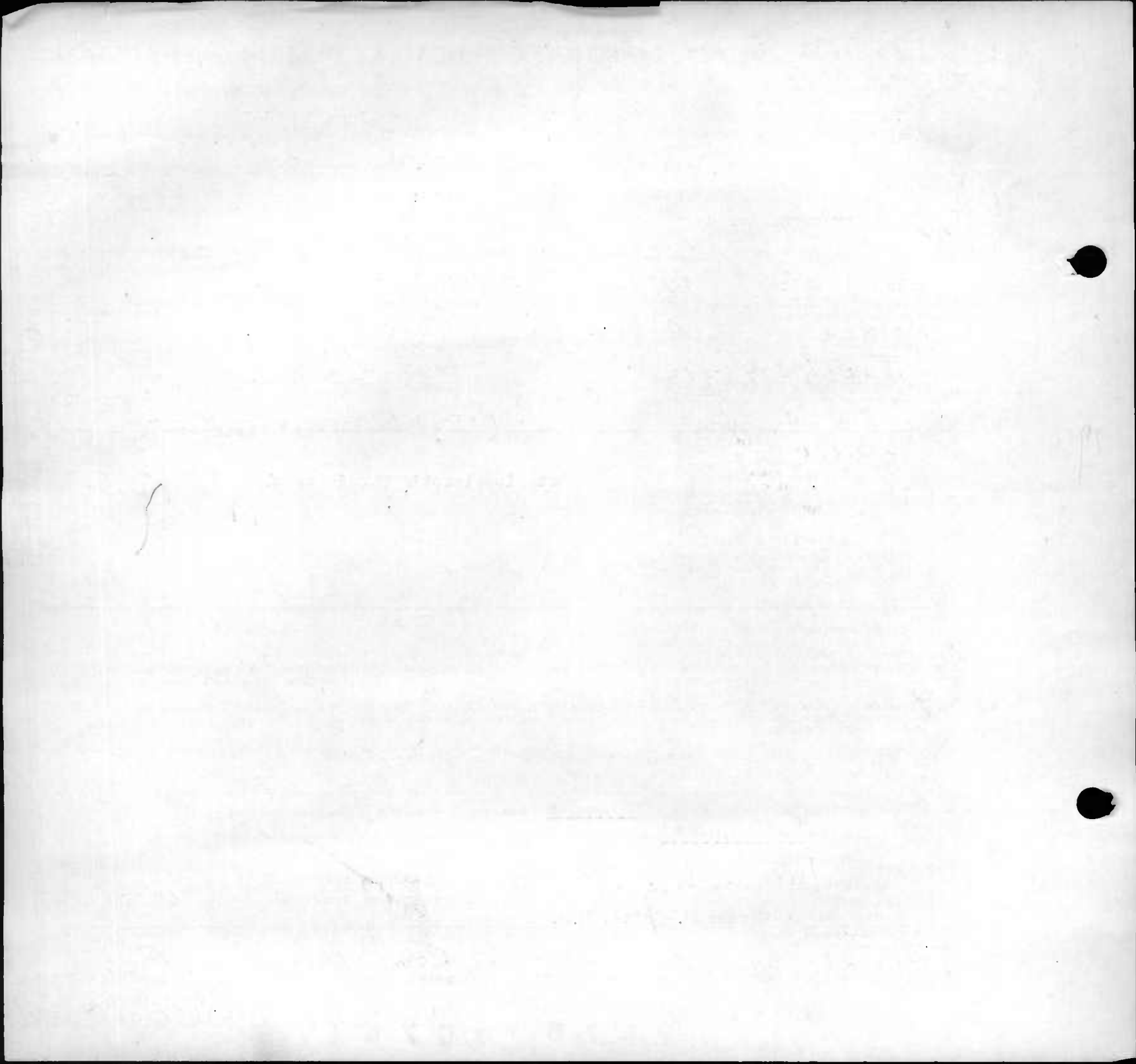
24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

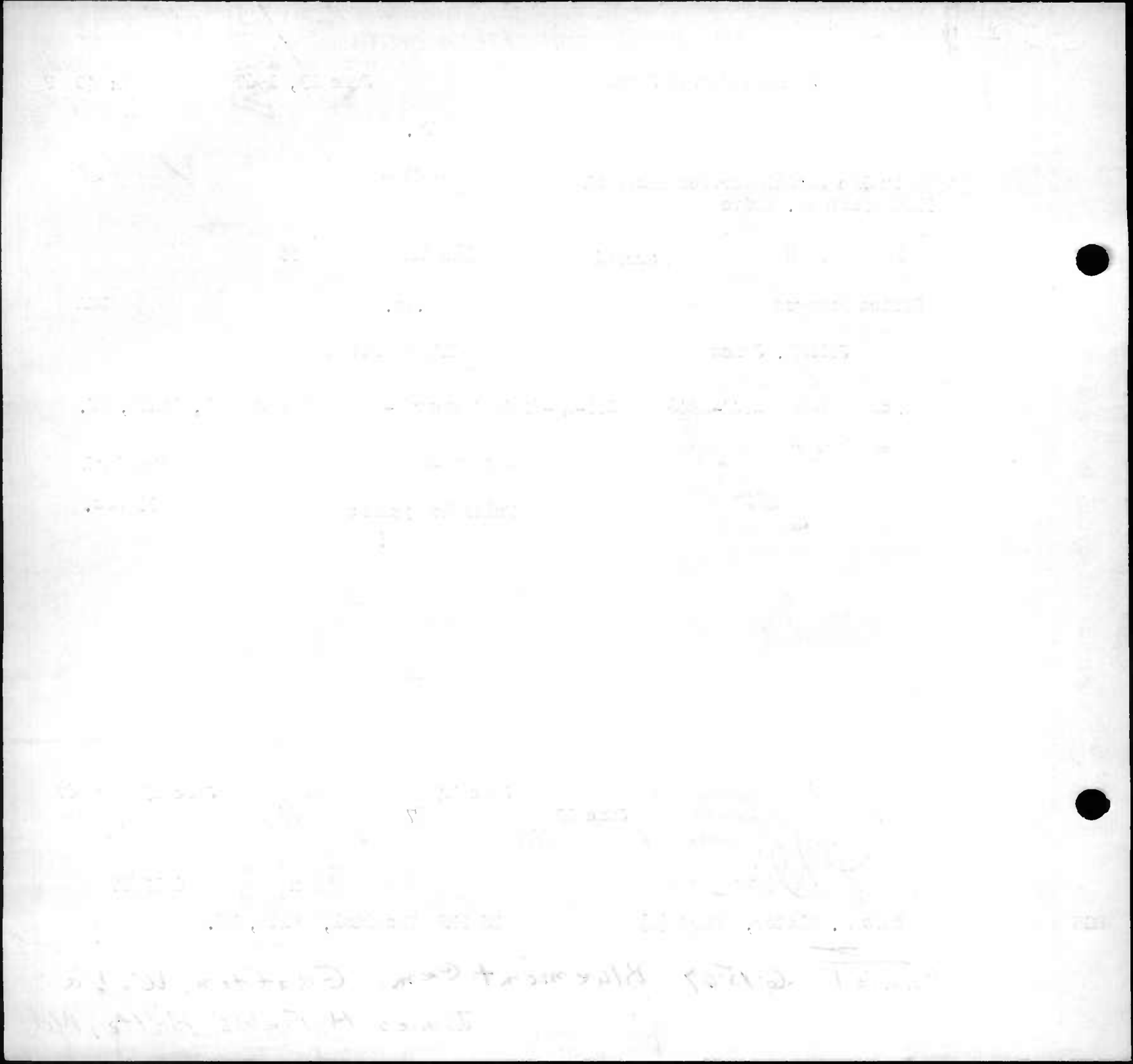
James M. Fields - Balt., Md.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 5752	
BIRTH NO. 67 5752		CERTIFICATE OF DEATH									
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John Frederick Jones						2. DATE AND HOUR OF DEATH June 13, 1967		1: 40 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						A. STATE Va.					
US Public Health Service Hospital 3100 Wyman Pk. Drive						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Norton					
						D. STREET ADDRESS (If rural, give location) V-43					
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 6/15/11		9. AGE (In years lost birthday) 55		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W.Va.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John R. Jones						14. MOTHER'S MAIDEN NAME Effie Wittman					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes USA 1944-1946				16. SOCIAL SECURITY NO. 233-10-6592		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.					
18. CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)										Pneumonia	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)										Multiple myeloma	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										Terminal	
II										33 mos.	
MEDICAL CERTIFICATION											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from June 22 19 66 to June 13 1967, that (1)/(we) last saw the deceased alive on June 13 19 67 and that in (1)/(our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE [Signature]										23B. DATE SIGNED 6/13/67	
23C. PHYSICIAN'S NAME (Type) Lewis M. Slater, Surg (R)						23D. ADDRESS M.D. US PHS Hospital, Balto, Md.					
24A. BURIAL CREATION, REMOVAL (Specify) Burial				24B. DATE 6-15-67		24C. NAME OF CEMETERY OR CREMATORY Bluemont Cem.				24D. LOCATION (City, town, or county) (State) Grafton, W. Va.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967				25B. NAME OF REGISTRAR [Signature]				25C. FUNERAL DIRECTOR ADDRESS James M. Fields - Balto, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
67 5753				67 5753	
CUMBERLAND, MD - 67 5753					
CERTIFICATE OF DEATH					
BIRTH NO. <i>Cumberland, Md</i>		67 5753		2. DATE AND HOUR OF DEATH <i>6-12-67 208 a</i>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Michael Kevin Sweetzer</i>		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Allegheny</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>33 Johns Hopkins Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Cumberland 51-02</i>			
D. STREET ADDRESS (If rural, give location) <i>324-B Waverly Terrace</i>					
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>5/16/67</i>	9. AGE (In years last birthday) <i>28</i>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <i>Roy Sweetzer</i>			14. MOTHER'S MAIDEN NAME <i>Sandra</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>756.21</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Aspiration Pneumonitis</i> DUE TO		<i>20 hrs.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Tracheo-Esophageal Fistula - (repaired)</i> DUE TO		<i>3 1/2 wks</i>	
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Imperforate Anus</i>					
19A. DATE OF OPERATION <i>5/17/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>TE fistula; imperforate anus</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/12/67</i> to <i>6/12/67</i> that (I) (we) last saw the deceased alive on <i>6/12/67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Herbert M. Swick</i> M.D.				23B. DATE SIGNED <i>6/12/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>HERBERT M. SWICK</i>		23D. ADDRESS <i>Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/14/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Snyders E.U.B. Cemetery</i>	
24D. LOCATION <i>Martinsburg, Berkeley, W.Va.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 14 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Donald C. Calkins, Hopewell, W.Va.</i>	

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5754

BIRTH NO. 67 5754

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN V. TROMBOILLE

2. DATE AND HOUR PRONOUNCED DEAD

June 12, 1967 4:05 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 Calvert & Barre Sts. (Police Boat)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **MARYLAND** B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

BALTIMORE 1939 N. COLLINGTON AVE

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

DIVORCED

8. DATE OF BIRTH

MARCH 8, 1931

9. AGE (In years last birthday)

36

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

CEMENT FINISHER

11. BIRTHPLACE (State or foreign country)

ELKINS WEST VIR.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOSEPH R. TROMBOILLE

14. MOTHER'S MAIDEN NAME

LAURA EARY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

YES

16. SOCIAL SECURITY NO.

17. INFORMANT

BONNIE SEEK FORD 1939 N. COLLINGTON AVE

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Drowning**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Acute ethylism**

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Acute ethylism

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

water

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Calvert & Barre Streets West of Pier #1.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

6-12-67 2:30 A.M.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Swimming

22-01

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 12, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

JUN 16 1967

23C. NAME OF CEMETERY or CREMATORY

U.S. NATIONAL CEM.

23D. LOCATION

ELKINS WEST VIRGINIA

24A. DATE REC'D BY HEALTH DEPT.

JUN 14 1967

24B. NAME OF REGISTRAR

Robert E. Faldut

24C. FUNERAL DIRECTOR

RUNNERS FUNERAL HOME

ADDRESS

ELKINS W. VA.

1947

27011-205

27011-205

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5755	
BIRTH NO. 67 5755		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PENNING ADA F.		2. DATE AND HOUR OF DEATH jun 11, 1967 2A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP		A. STATE MARYLAND			
		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 12-06			
		D. STREET ADDRESS (If rural, give location) 217 West 27th Street			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH July 17-1885	9. AGE (In years last birthday) 81	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mr G. M. Pletzer nephew from short	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO Cerebro-Vascular Accident		5 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Generalized Arteriosclerosis			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from May 27, 1967 to June 11, 1967, that (we) last saw the deceased alive on June 11, 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Giselle T. Bretz M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 11, 1967	
23C. PHYSICIAN'S NAME (Type) Giselle T. Bretz		23D. ADDRESS THE UNION MEMORIAL HOSPITAL Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/14/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery BALTO. Md.	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Borgey Funeral Home 3630 Falls Rd	

10/10/1911

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10/10/1911

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5756	
67 5756				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				MARGIE B. HAINES	
2. DATE AND HOUR OF DEATH		6/10/67 11 ¹⁰ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
48 MARYLAND GENERAL HOSPITAL		MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		3543 CHESTNUT AVE 21211			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
F	W	WIDOWED	05/21/86	81	HOUSEWIFE
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOSEPH FORM WALT		EMMA GEIGER		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				HOSPITAL CHART	
18. 155.01		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Hepatoma -			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) Obs. Jaundice			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
		(C) Cholelithiasis			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 6/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Elisabeth Kandel M.D.				6/10/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Elisabeth Kandel				MARYLAND GENERAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		6/13/67		LORRAINE PARK Cem.	
				BALTO. CO MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 14 1967		Robert E. Fajana		Burger Funeral Home 3601 Falls Rd	

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B-630

67 5757

BALTIMORE CITY HEALTH DEPARTMENT

67 5757

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LOCK CRAIG BROADWAY

2. DATE AND HOUR PRONOUNCED DEAD

5-26-67

3:40 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

135 N. BROADWAY - Amb. Crew #7

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

135 N. Broadway 21205

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Lobar pneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic cardiovascular disease

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

R. S. Fisher

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

5-27-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

6-9-67

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 15 1967

Robert E. Fisher, M.D.

5-27-67

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

WILLIAM H. HARRIS
JAN 11 1894
FREDERICK

46-98-41TN

5-20

67 5758

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

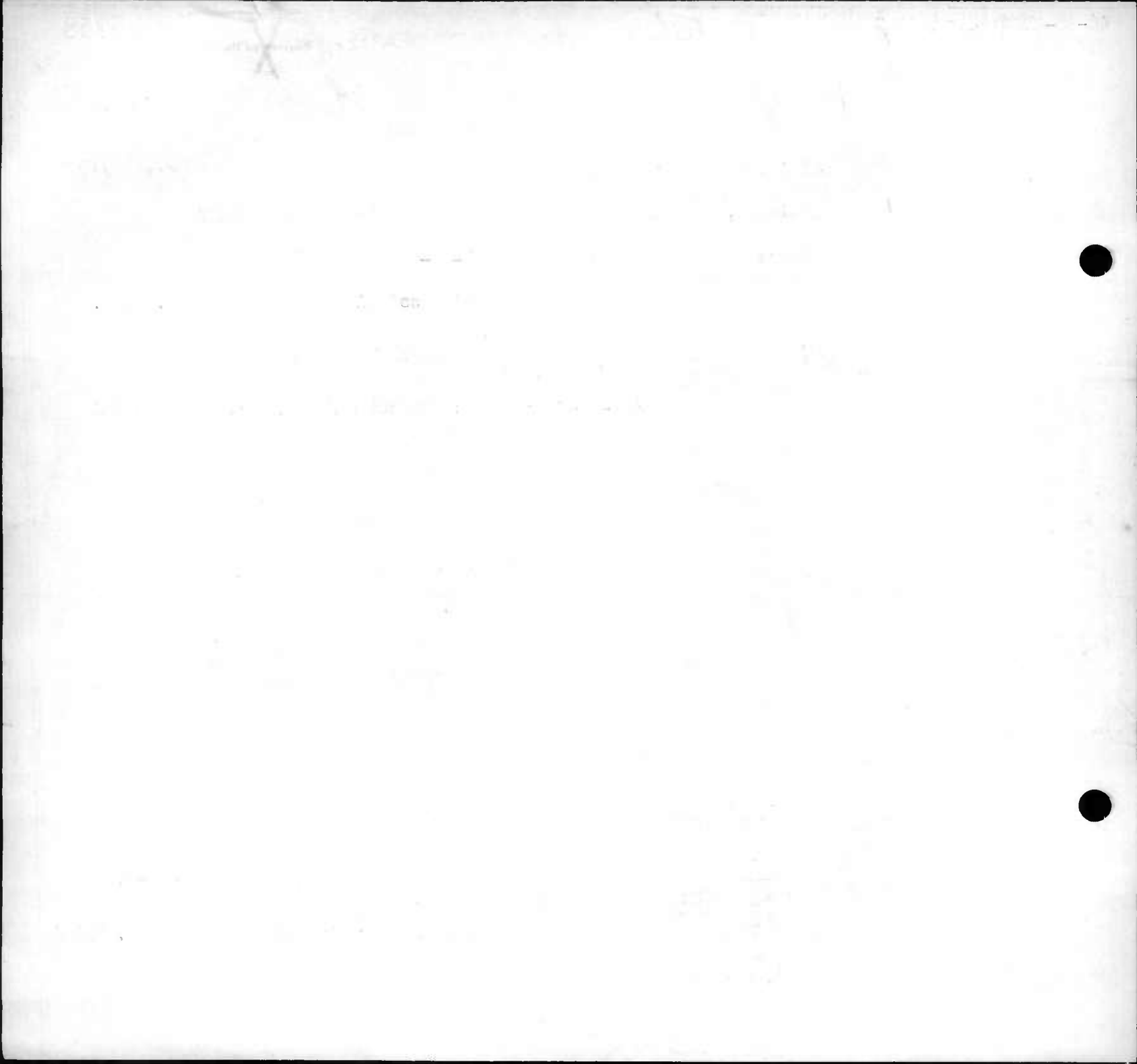
Registered No.

67 5758

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

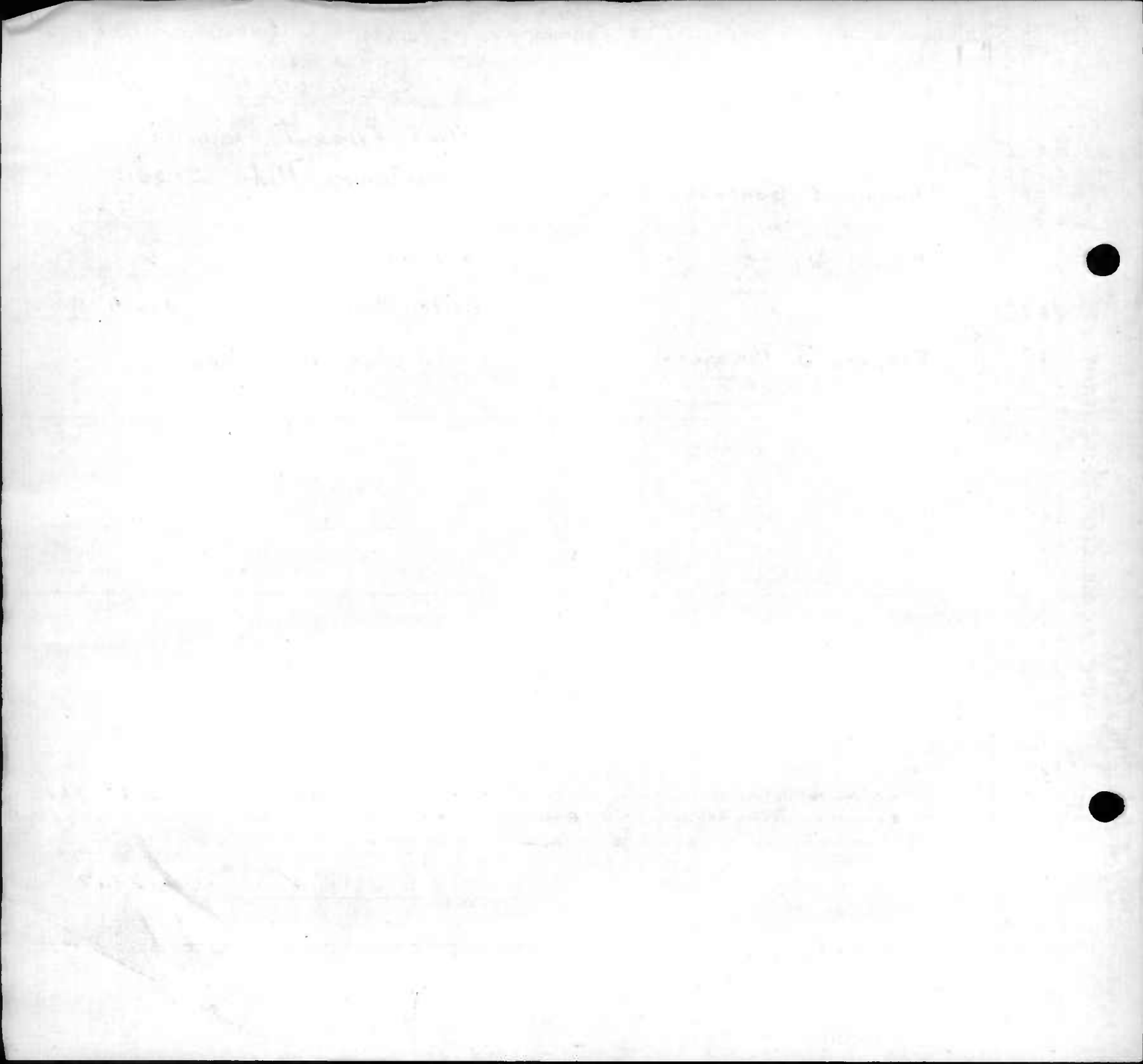
BIRTH NO. 5-20		67 5758		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5758	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Jones, Fletcher</u>				5/29/67 1:15 a. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MARYLAND</u>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>537 Argyle Avenue 21217</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>Single</u>	8. DATE OF BIRTH <u>1-16-36</u>	9. AGE (In years last birthday) <u>31</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>EDWARD JONES</u>				14. MOTHER'S MAIDEN NAME <u>CAROLYN WHITAKER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>427-64-7755</u>		17. INFORMANT ADDRESS <u>BCH: RECORDS 4940 Eastern Avenue 21224</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>330X I</u> <u>Cardiac arrest</u>				INTERVAL BETWEEN ONSET AND DEATH <u>hours.</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>C.U.A. (subarachnoid hemorrhage - hours)</u> (C) <u>Hypertension</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Disseminated sarcoidosis</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>5/28</u> 19 <u>67</u> to <u>5/29</u> 19 <u>67</u> , that <u>(H)</u> (we) last saw the deceased alive on <u>5/29</u> 19 <u>67</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Carl Winterstein</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5-29-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Carl Winterstein</u>				23D. ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>6-8-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>		24D. LOCATION (City, town, or county) (State) <u>MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 15 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Faber</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

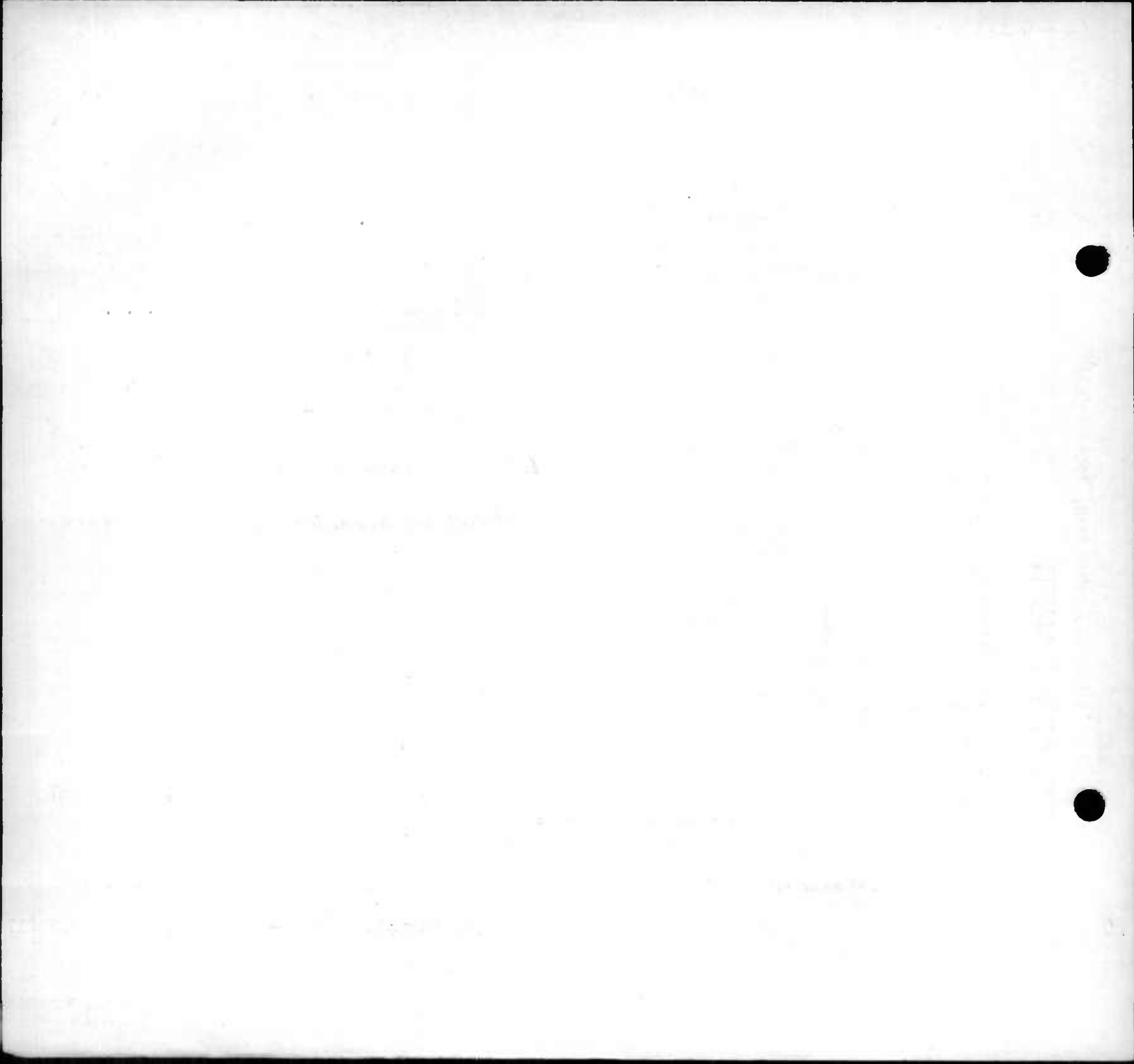
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5759	
BIRTH NO. 67-10597 67 5759					
CERTIFICATE OF DEATH					
M.E. CASE NO.		2. DATE AND HOUR OF DEATH JUNE 6 - 67 11 05 P.M.			
1. NAME OF DECEASED (Type or Print) Baby Girl Beaman					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO.			
FULL NAME OF HOSPITAL OR INSTITUTION 8 Maryland General Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Md. 21204			
		D. STREET ADDRESS (If rural, give location) 53-00			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) N.B.	8. DATE OF BIRTH JUNE 1 - 67	9. AGE (In years last birthday) 6	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., MD.	
13. FATHER'S NAME Stephen J. Beaman		14. MOTHER'S MAIDEN NAME Hendrika A DeBro			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 726X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Imaturity		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from JUNE 1 - 1967 to JUNE 6 - 1967 , that (he) (we) last saw the deceased alive on JUNE 6 - 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Richard J. Heilly		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED JUNE 6 - 67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.O.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6-9-67		24C. NAME of CEMETERY or CREMATORY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR MORTUARY SERVICE	
				ADDRESS BCHD	



FUNERAL DIRECTOR: IMPORTANT

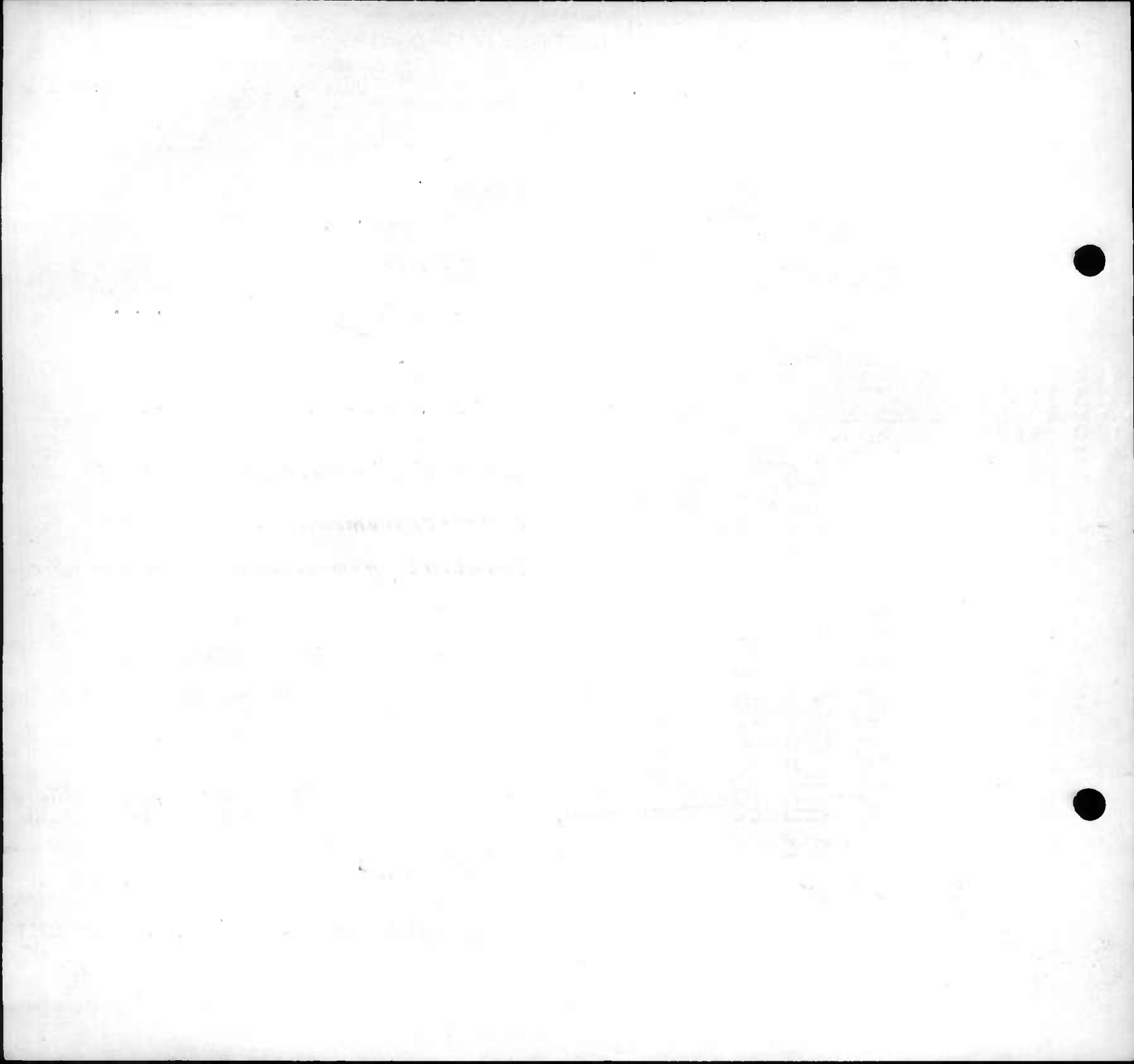
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5760</u>	
BIRTH NO. <u>67-11287</u>		67 5760		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>June 7, 1967</u> <u>10:05 a. M.</u>			
1. NAME OF DECEASED (Type or Print) <u>Baby of Angelita Gross</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>15-04</u> D. STREET ADDRESS (If rural, give location) <u>1922 N. Payson Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>single</u>	8. DATE OF BIRTH <u>June 6, 1967</u>	9. AGE (In years last birthday) <u>32</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Eugene Lemmon</u>		14. MOTHER'S MAIDEN NAME <u>Angelita Gross</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Angelita Gross-mother</u> ADDRESS <u>same</u>	
18. <u>754.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>INTERVENTRICULAR SEPTAL DEFECT.</u> INTERVAL BETWEEN ONSET AND DEATH <u>32 hours.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ATELECTASIS NEONATORUM.</u> INTERVAL BETWEEN ONSET AND DEATH <u>32 hours.</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Inter-ventricular Septal Defect.</u> DUE TO (B) <u>Atelectasis Neonatorum.</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>32 hours.</u> <u>32 hours.</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 6, 1967</u> to <u>June 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 7, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Morraud Kaye</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>June 8, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>Kaye</u>		23D. ADDRESS M.D. <u>1514 Division Street-Baltimore, Maryland 21217</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>6-9-67</u>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR <u>Robert E. Taylor</u>		24F. FUNERAL DIRECTOR <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 15 1967</u>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
25D. ADDRESS		25E. ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

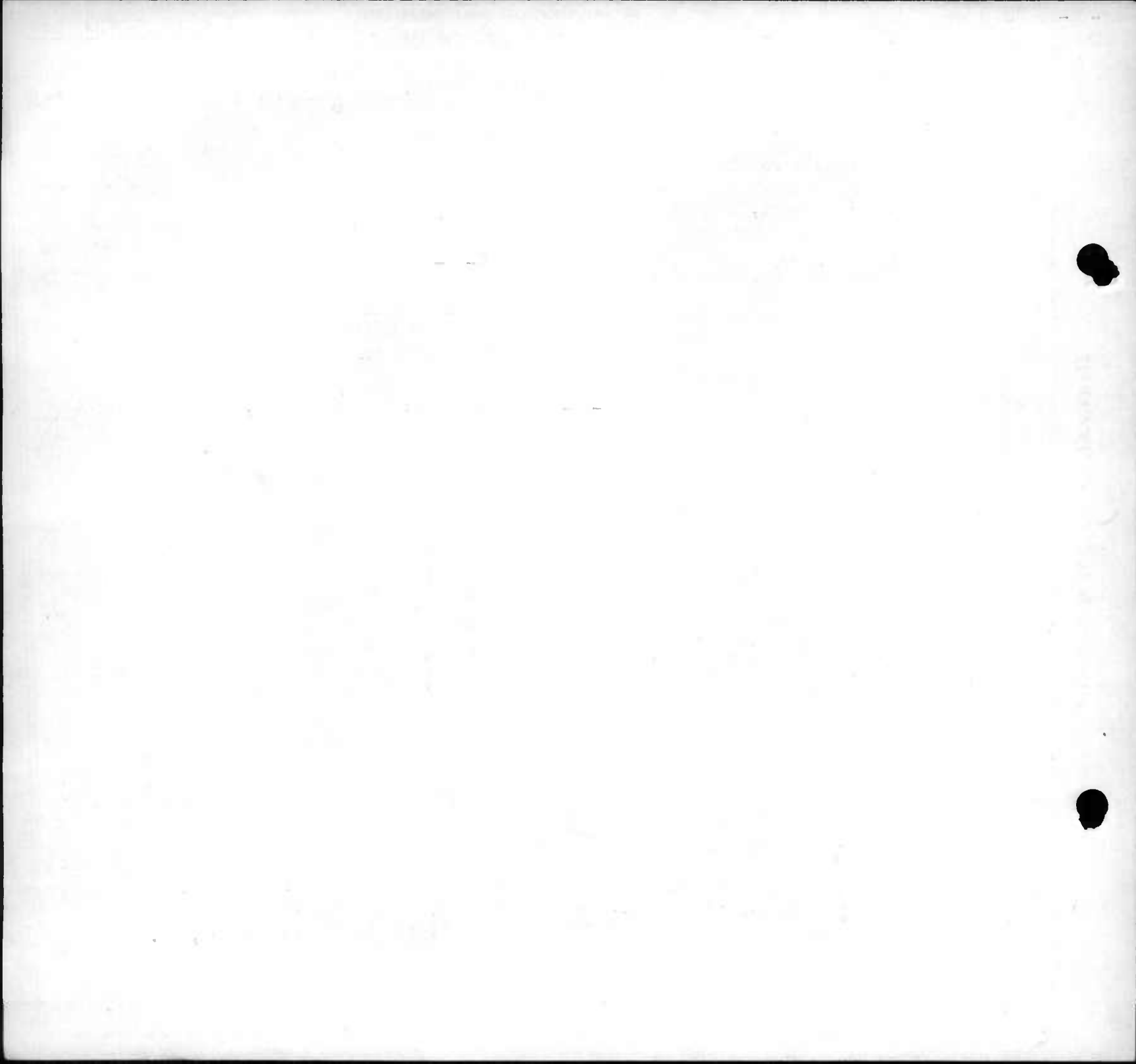
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5761	
BIRTH NO. 47-10673 67 5761		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Baby of Alma R. Smith		June 6, 1967 6:45 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Division Street Baltimore, Maryland			A. STATE Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 1819 W. Franklin Street		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH May 31, 1967	9. AGE (In years last birthday) 6	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Clifton Garner			14. MOTHER'S MAIDEN NAME Alma R. Smith		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Alma R. Smith-mother	
18. 732X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Congenital Hydrocephalus</u> DUE TO (B) <u>Bronchopneumonia</u> DUE TO (C) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>3 days</u> <u>few hours after birth.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 31,</u> 19 <u>67</u> to <u>June 6,</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 6,</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Nassoud Kaye</u>				23B. DATE SIGNED June 7, 1967	
23C. PHYSICIAN'S NAME (Type) Kaye		23D. ADDRESS M.D. <u>1514 Division Street-Baltimore, Maryland 21217</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>6-8-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE RECEIVED BY HEALTH DEPT. <u>JUN 15 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BOND</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

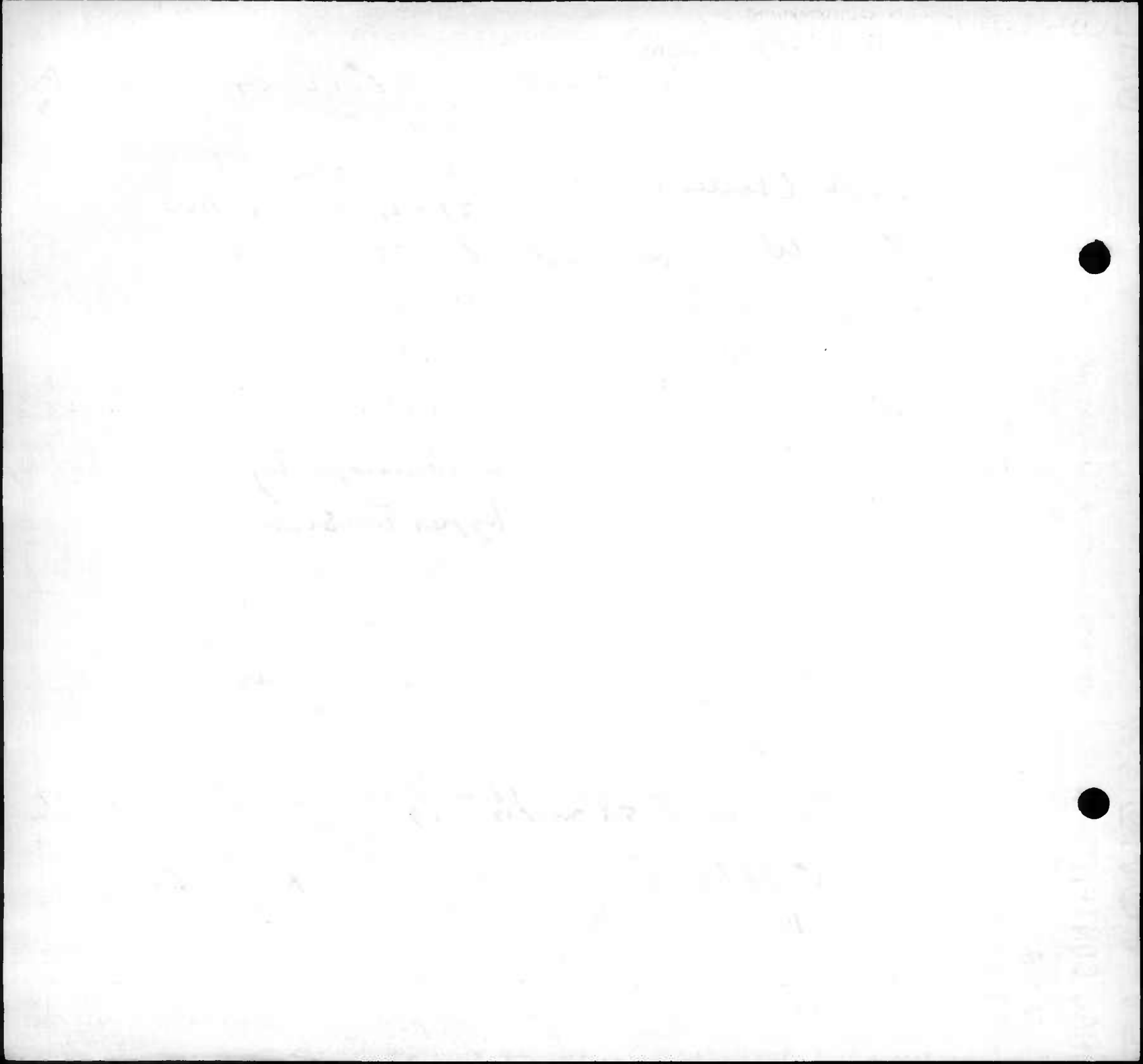
S-500		67 5762		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5762	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) SWAIN ALFRED (Alfred Swain)				5/27/67 8:15 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 31 4940 Eastern Avenue Baltimore, Maryland #21224				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-12 D. STREET ADDRESS (If rural, give location) (Homeless)			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 8-12-12	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 415-20-3725		17. INFORMANT BCH 4940 Eastern Avenue RECORDS: Baltimore, Maryland #21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION CAUSING IT. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO TB of Brain (B) DUE TO (C) DUE TO			
19A. DATE OF OPERATION 2 4/30				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED COMA		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/27 4/30 to 5/27 19 67, that (I) (we) last saw the deceased alive on 5/27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stuart Beal Silver				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/27/67	
23C. PHYSICIAN'S NAME (Type) STUART BEAL SILVER				23D. ADDRESS 4940 Eastern Avenue BALTIMORE, MARYLAND #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) 6-8-67		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1967		25B. NAME OF REGISTRAR R. B. E. Faller, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5763 (BARANOSKI) CERTIFICATE OF DEATH					Registered No. 67 5763				
1. NAME OF DECEASED (Type or Print) MaryAnn Wojcik					2. DATE AND HOUR OF DEATH 8.12.67 6.30 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 49 North Charles Hays.					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 1-05 D. STREET ADDRESS (If rural, give location) 2104 Eastern Ave.				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) divorced		8. DATE OF BIRTH 6-6-36	9. AGE (In years last birthday) 31 yrs.	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAY ROLL CLERK				10B. KIND OF BUSINESS OR INDUSTRY HARLEYS SANDWICH SHOPS		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BERNARD BARANOSKI					14. MOTHER'S MAIDEN NAME JULIA ALEKSALZA				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219-32-7835		17. INFORMANT B. BARANOSKI ADDRESS 1320 WESTBURN RD. BALTO. MD. 21228			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 334X1 ENCEPHALOPATHY ANTECEDENT CAUSES hypertension DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. recent					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? m		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initally medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1 P.M. 6.12.1967 to 6.30 P.M. 6.12.1967 that (I) (we) last saw the deceased alive on 5 P.M. 6.12.1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE F. Libary					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6-12-67	
23C. PHYSICIAN'S NAME (Type) Niznik					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-16-67		24C. NAME of CEMETERY or CREMATORY Holy Rosary Cem.			24D. LOCATION (City, town, or county) (State) BALTO. Co. MD.		
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1967		25B. NAME OF REGISTRAR Wm. J. Fialkowski			25C. FUNERAL DIRECTOR Wm. J. Fialkowski			ADDRESS 2007 EASTERN AVE. 21231	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 5764

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 5764

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANNA AMELIA RAMMEL

2. DATE AND HOUR OF DEATH

June 11, 1967

9:25 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)00
407 S. Robinson St.
Baltimore, 21224, Md.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore # 21224, 1-02

D. STREET ADDRESS (If rural, give location)

407 S. Robinson St.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Jan. 10, 1892

9. AGE (In years
last birthday)

75

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

House Work

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Peter Bauernschub

14. MOTHER'S MAIDEN NAME

Elizabeth Thom.

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Catherine Cumberland 1424 Dundalk Ave. # 24.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, oshterio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C) DUE TO

5 hrs.

8 hrs.

10 yrs.

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/21 1960 to 6/11 1967,
that (I) (we) last saw the deceased alive on 6/11 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Henry J. Houska

M.D.

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

6/12/67

23C. PHYSICIAN'S
NAME (Type)

Henry J. Houska

M.D.

23D. ADDRESS

333 S. East Ave., Balto., 21224, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-14-67.

24C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

(City, town, or county)

(State)

4430 Belair Rd., Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 15 1967

25B. NAME OF REGISTRAR

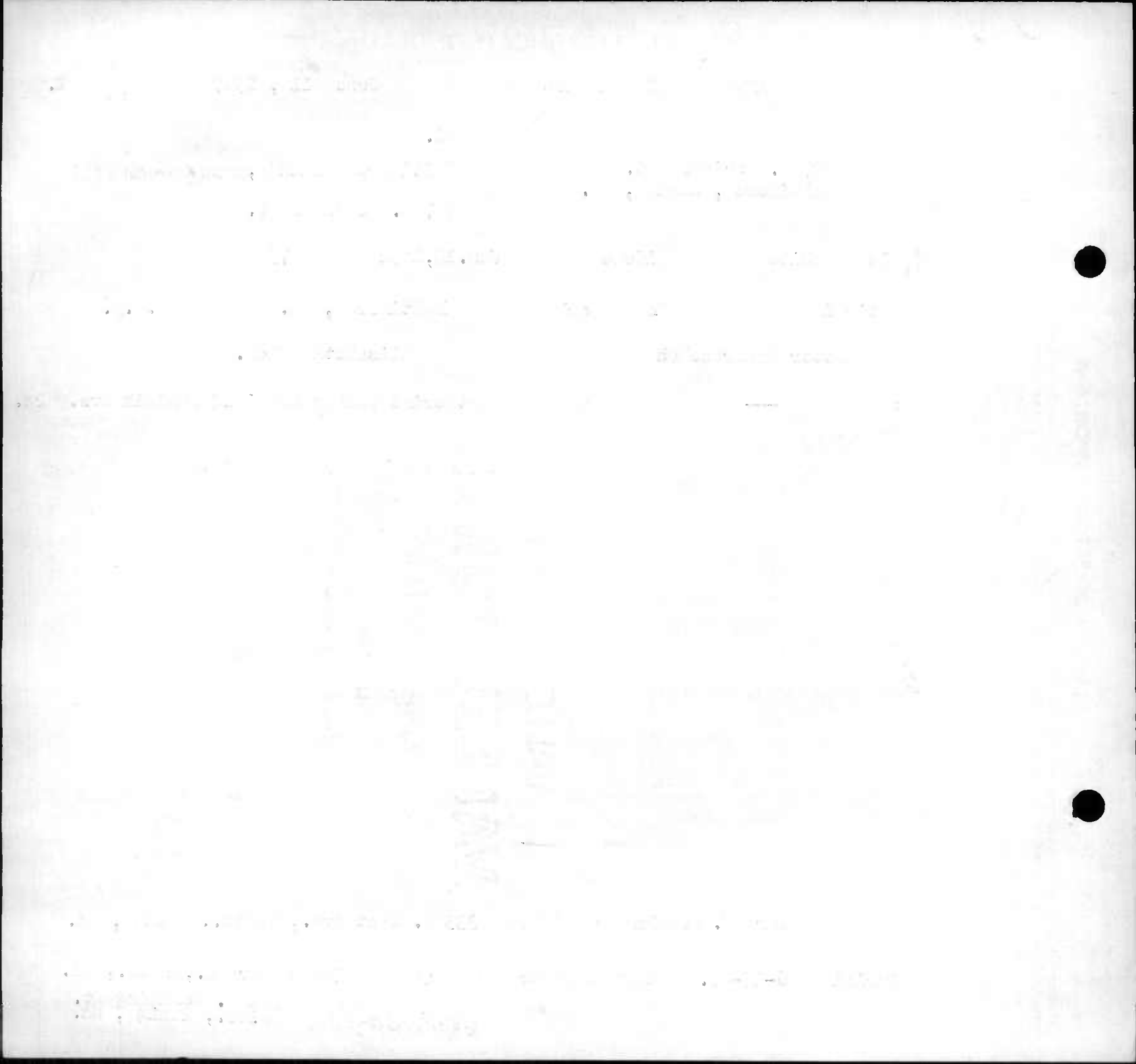
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Charles J. Jester

901 S. Conkling St.

Balto., 21224, Md.



1
M-200
M-620

67 5765		BALTIMORE CITY HEALTH DEPARTMENT		67 5765	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		GEORGE MACK (OR MARK)		2. DATE AND HOUR PRONOUNCED DEAD 6-13-67 4:30 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 2006 Greenmount Avenue			
FULL NAME OF HOSPITAL OR INSTITUTION 2006 GREENMOUNT AVENUE					
5. SEX Male	6. RACE Yellow	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED-?	8. DATE OF BIRTH UNKNOWN	9. AGE (In years last birthday) 72	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) CHINA	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) ? Doubtful		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Robert Lew - Park Ave - City	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Arteriosclerotic cardiovascular disease DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 6-14-67					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/14/67		23C. NAME OF CEMETERY or CREMATORY Lorraine	
23D. LOCATION (City, town, or county) (State) Woodlawn - Md.					
24A. DATE REC'D BY HEALTH DEPT. JUN 15 1967		24B. NAME OF REGISTRAR Robert E. Fisher		24C. FUNERAL DIRECTOR STEWART & MOWEN Co - City	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-620		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 5766</u>	
BIRTH NO. <u>67 5766</u> M.E. CASE NO. <u>EDGAR</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Russell Myers</u>		2. DATE AND HOUR OF DEATH <u>13 June 1967</u> <u>3:15</u> P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>University of Maryland Hospital</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Carroll Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Westminster</u> D. STREET ADDRESS (If rural, give location) <u>212 Liberty Street</u>			
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>3-13-15</u>	9. AGE (In years lost birthday) <u>52</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Myers -</u>		14. MOTHER'S MAIDEN NAME <u>Jenny Williams</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>not known</u> <u>VVWH 1941-1945</u>		16. SOCIAL SECURITY NO. <u>not known</u>		17. INFORMANT <u>Patient's Chart</u>	
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Multiple Myeloma</u> II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Left Lower Lobe Pneumonia</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u> <u>5 days</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/27/67</u> 19 to <u>13 June</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>13 June 67</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Kouben</u>				23B. DATE SIGNED <u>13 June 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>Sidney Stapleton, Jr.</u>				23D. ADDRESS <u>University of Maryland Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/16/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>ST. JAMES CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>DENNING-S, CARROLL, MD</u>		25A. DATE REC'D IN DEATH CERT. <u>JUN 15 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Saffell</u>	
25C. FUNERAL DIRECTOR <u>254 E. MAIN ST. WESTMINSTER MD.</u>					

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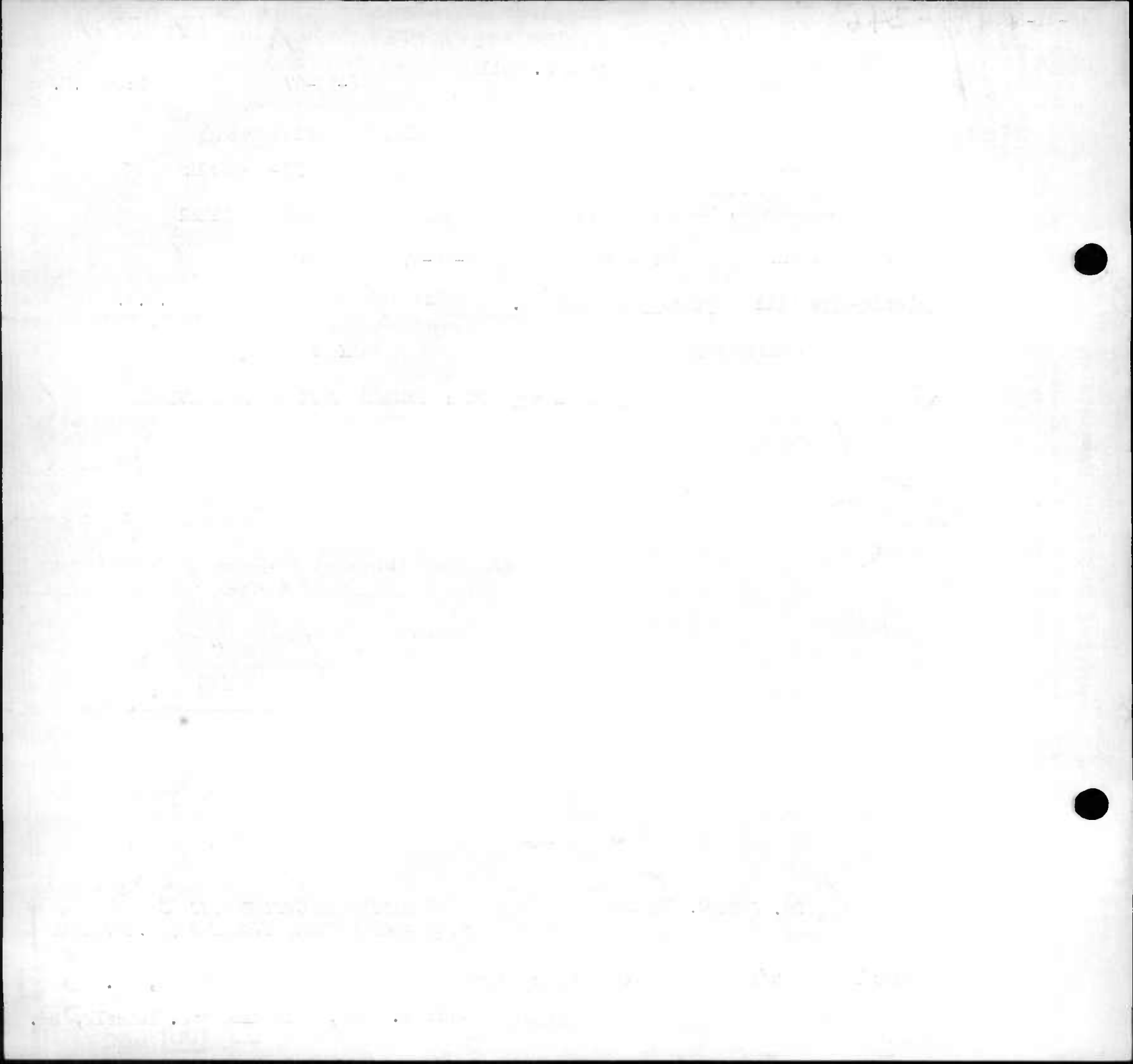
1960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 67 5767		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) VANCE BUTLER		2. DATE AND HOUR OF DEATH 6-13-67 2:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE COUNTY - Dundalk D. STREET ADDRESS (If rural, give location) 205 OAKWOOD ROAD 21222	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-20-07
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic-Pipe Mill		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.	9. AGE (In years last birthday) 60
13. FATHER'S NAME JOHN BUTLER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-3381	
17. INFORMANT BCM: RECORDS		ADDRESS 4940 EASTERN AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARDIAC ARREST DUE TO (B) ANOXIA + Respiratory failure DUE TO (C) Chronic obstructive pulmonary disease		INTERVAL BETWEEN ONSET AND DEATH 90 mins. 1 hr 35 mins Several years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Possible acute myocardial infarct.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1230 June 13th 1967 to 2:00 am June 13th 1967 , that (I) (we) last saw the deceased alive on June 13th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE John C. Wheelton		23B. DATE SIGNED 6/13/67	
23C. PHYSICIAN'S NAME (Type) DR. JOHN C. WHELTON		23D. ADDRESS BALTIMORE CITY HOSPITALS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/67	
24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1967		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	

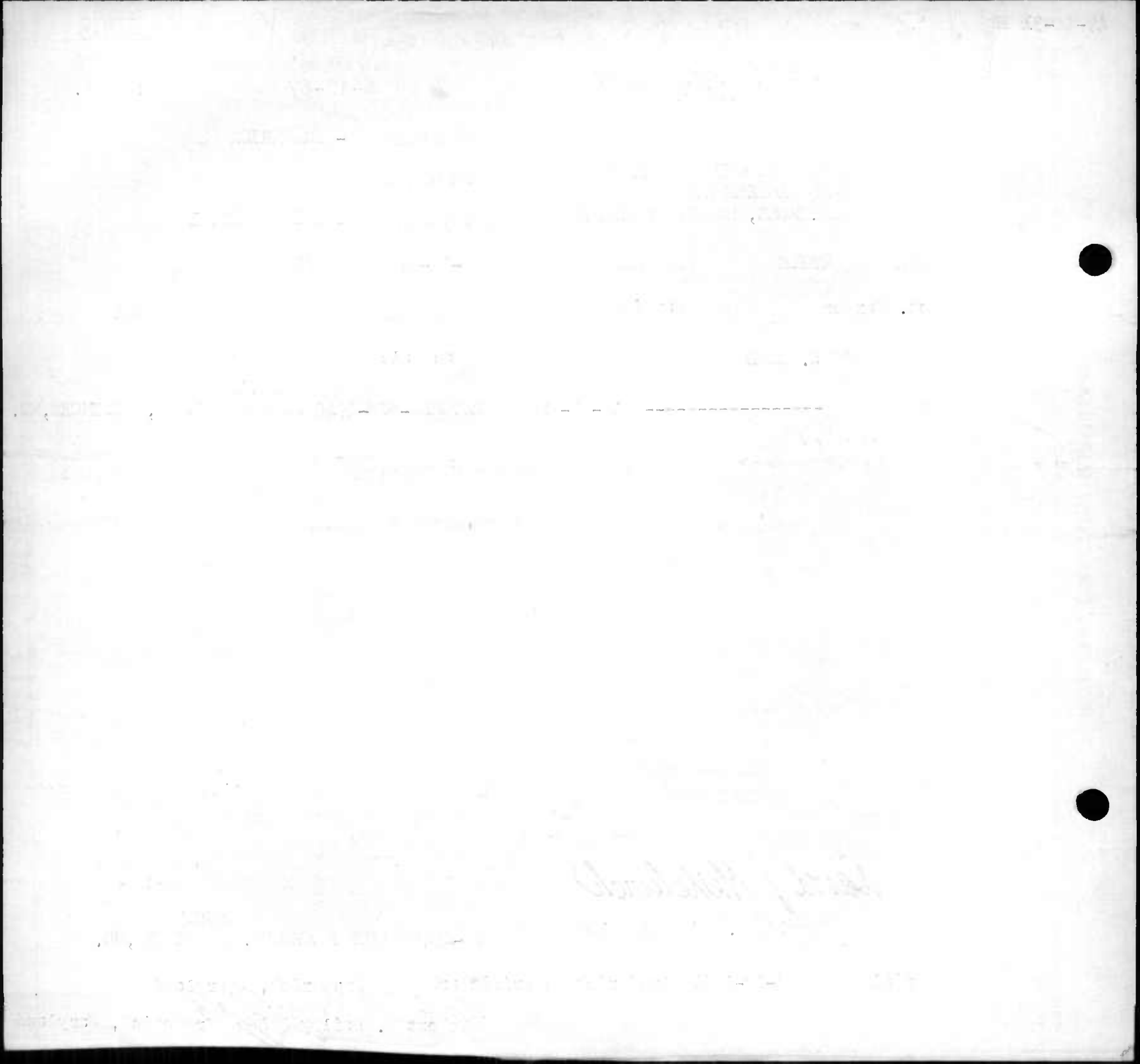


49-44-31 D

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

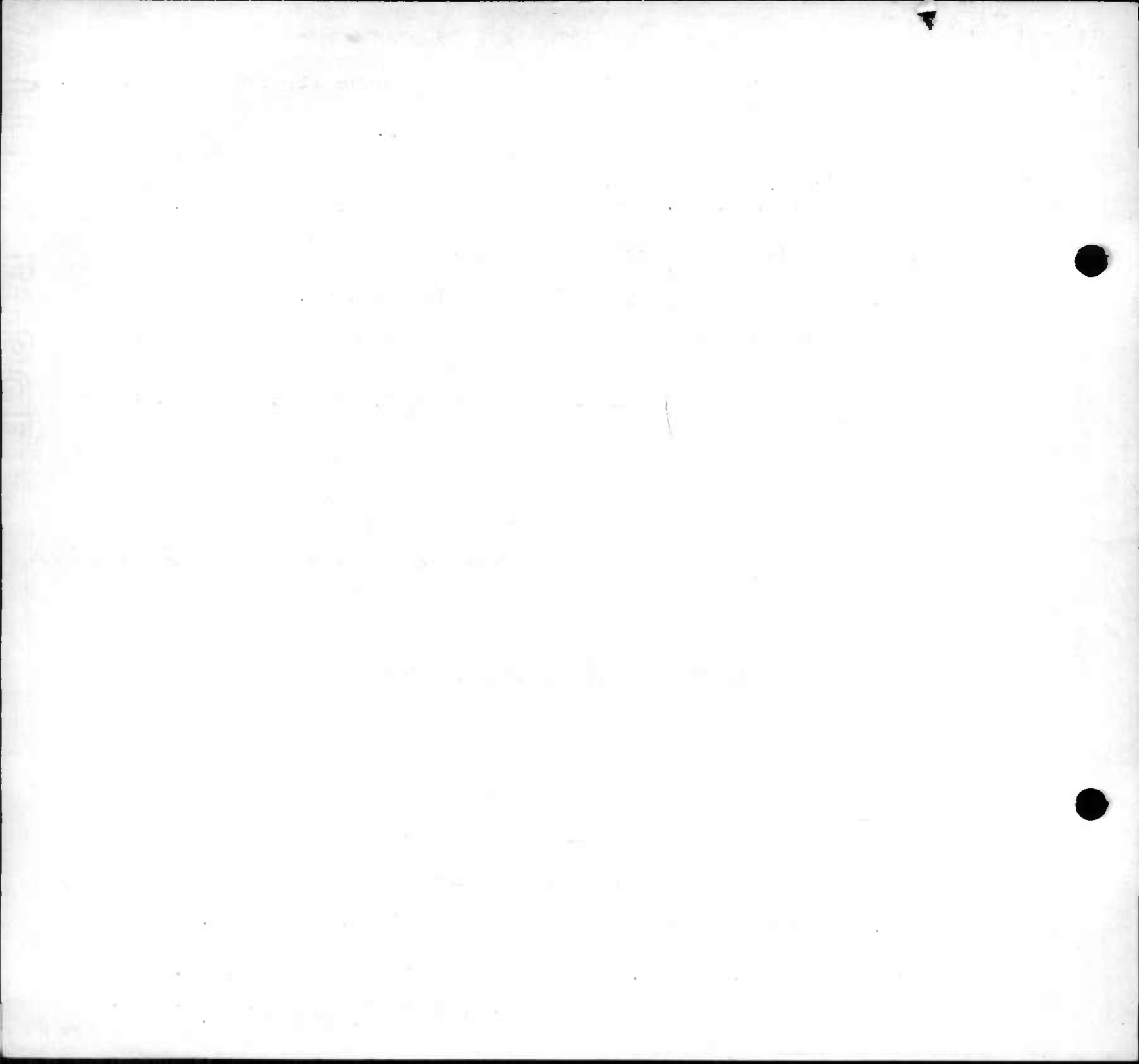
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5768	
BIRTH NO. R-000 67 5768					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) HENRY HARRISON ROWE XXXXXXXXXXXXXX			2. DATE AND HOUR OF DEATH 6-12-67 15:53 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		
FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224			MARYLAND - FREDERICK Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) FREDERICK 60-11 D. STREET ADDRESS (If rural, give location) 339 MARKET STREET #21701		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-14-17	9. AGE (In years last birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10B. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME HENRY R. ROWE		
14. MOTHER'S MAIDEN NAME Mae Kale			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 218-28-8329			17. INFORMANT 21224 RECORDS-BCN-4940 EASTERN AVENUE, BALTIMORE, MD.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH (A) Leriche Syndrome 3 months (B) ASCVD, Severe Years (C)		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 6-8 19 67 to 6-12 19 67, that (I) (we) last saw the deceased alive on 6-12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE David J. Mischelevich M.D.				23B. DATE SIGNED 6-12-67	
23C. PHYSICIAN'S NAME (Type) David J. Mischelevich M.D.				23D. ADDRESS 21224 BCN-4940 EASTERN AVENUE, BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-15-1967		24C. NAME of CEMETERY or CREMATORY Frederick Memorial Park	
24D. LOCATION Frederick, Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1967		25B. NAME OF REGISTRAR Robert E. Darley		25C. FUNERAL DIRECTOR Robert E. Darley & Son	
ADDRESS Frederick, Maryland					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

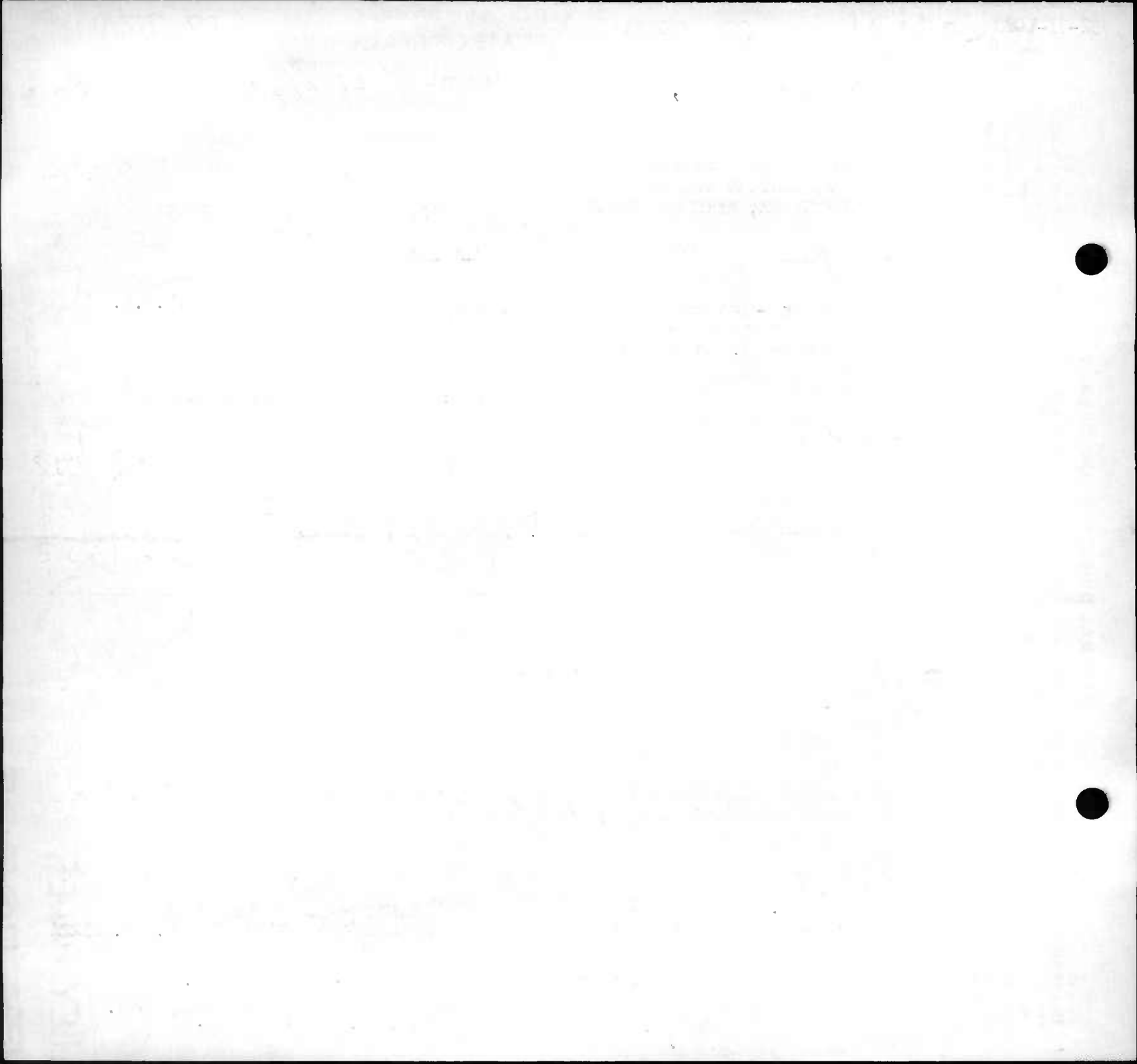
M-450

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5769	
BIRTH NO. 67 5769				CERTIFICATE OF DEATH	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MATILDA MALLON			June 11, 1967 3:45 a. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 907 N. Streeper St. Baltimore, Md. 21205			A. STATE Md. B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 907 N. Streeper St.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
female	white	married	12/20/1907	59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife		at home		Baltimore, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Anthony Olszewska			unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		219-07-1962		August C. Mallon, husband, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
18. 199.1 I			Interval BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES			(A) Bilateral Bronchopneumonia 48 hrs.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Bronchial Cyst Adeno- 18 months		
			(C) Carcinoma of Metastases		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0		Multiple Neck Tumors		no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/17 1966 to 6/11 1967, that (I) (we) last saw the deceased alive on 6/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Isadore Karl Grossman M.D.				4/13/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Isadore Karl Grossman M.D.				1527 E. North Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/15/67		St. Stanislaus Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 15 1967		Robert E. [Signature]		Schimunek Funeral Home, Inc. 2601 E. Madison St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5770		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5770	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GILLESPIE, Richard Vincent		2. DATE AND HOUR OF DEATH 6/12/67 8:05 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2727 ASHLAND AVENUE 21205			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 6-10-14	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver - Branch Motor Freight		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George W. Gillespie		14. MOTHER'S MAIDEN NAME Maude Powell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS BCN: RECORDS 4940 EASTERN AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANOXIA		CAUSE OF DEATH (A) DUE TO Bronchopneumonia (B) DUE TO TBC (C)		INTERVAL BETWEEN ONSET AND DEATH 12 days	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 6/1/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Infected Lung		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 5/4/67 to 6/12/67 and that (I) (we) lost saw the deceased alive on 6/12/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Pablo Trefogli		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/12/67	
23C. PHYSICIAN'S NAME (Type) DR. PABLO TREFOGGI		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO. MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/67		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 15 1967		25B. NAME OF REGISTRAR Pablo Trefogli	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		25D. ADDRESS 2601 E. Madison St.			



P-620

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 5771

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5771

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Preston HARVEY P. PRICE			2. DATE AND HOUR PRONOUNCED DEAD 6-12-67 10:10 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 FORT HOLABIRD - DOA			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2603 D. STREET ADDRESS (If rural, give location) 4115 Shannon Drive 21213		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 4/22/20	9. AGE (In years last birthday) 47	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refrigeration Mech			10B. KIND OF BUSINESS OR INDUSTRY Md. Refrigeration		11. BIRTHPLACE (State or foreign country) Blackburg, Va.
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME George M. Price		
14. MOTHER'S MAIDEN NAME Margie Long			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Navy WW 2 215-03-0291		
16. SOCIAL SECURITY NO. 215-03-0291			17. INFORMANT ADDRESS Anna Hillenbrand Price, wife, above		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4200 I Arteriosclerotic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) Anteriosclerotic heart disease (B) (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR?		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6-13-67	
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/16/67		23C. NAME OF CEMETERY or CREMATORY Balto. Nat. Cem.	
23D. LOCATION (City, town, or county) (State) Baltimore, Md.		24A. DATE REC'D BY HEALTH DEPT. JUN 15 1967			
24B. NAME OF REGISTRAR Robert E. Fisher		24C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane			

ARMY FORCE

ARMY FORCE

ARMY FORCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-14348 67. 5772		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5772	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Boy Johnson		2. DATE AND HOUR OF DEATH 6/10/67 6 20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hosp. 33		A. STATE Maryland		B. COUNTY BALTIMORE	
6. SEX M		7. RACE Negro		8. DATE OF BIRTH 6/9/67	
9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		10. AGE (In years last birthday) 6		11. If Under 1 Yr. Months: Days: Hours: Min. 6 35	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10B. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Theodore Johnson		14. MOTHER'S MAIDEN NAME Annie W. Mann	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mother	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO CARDIAC ARREST			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO PULMONARY ARREST			
		(C) DUE TO hyaline membrane disease.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		None			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6/9/67 to 6/10/67 that (I) (we) last saw the deceased alive on 6/10/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE James B. Brayton M.D.		23B. DATE SIGNED 6/10/67	
23C. PHYSICIAN'S NAME (Type) JAMES B. BRAYTON M.D.		23D. ADDRESS The Johns Hopkins Hospital Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 6-12-67		24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS HOSP.	
24D. LOCATION BALTIMORE, MD.		25A. DATE REC'D BY HEALTH DEPT. JUN 15 1967		25B. NAME OF REGISTRAR Robert E. Talbot	
25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		25D. ADDRESS			

Wagland Baltimore
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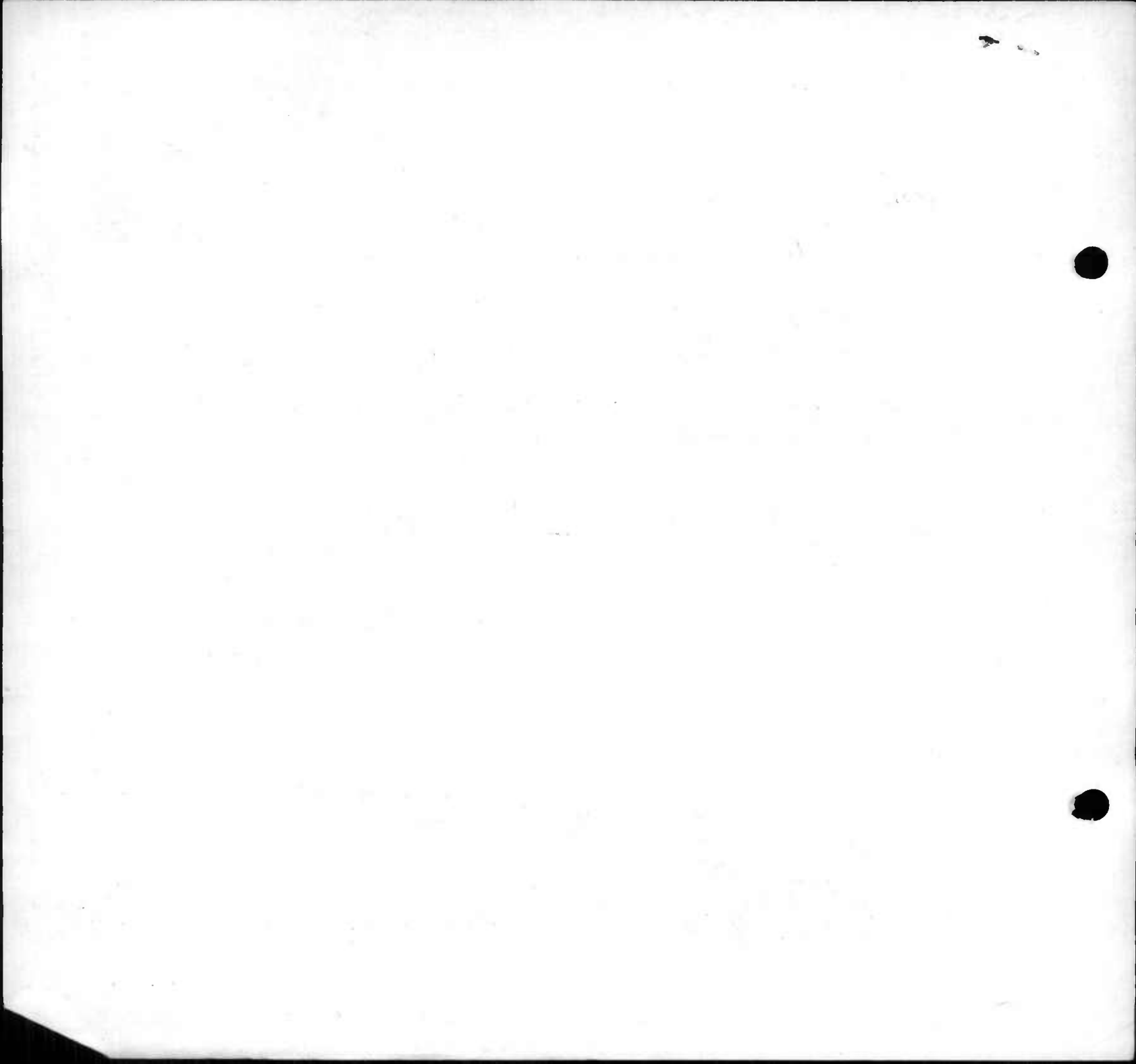
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1905

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 5773		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5773	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Wyatt JOHN Samuel		6-12-67		9 P.M.	
3. PLACE OF DEATH (IN BALTIMORE, MARYLAND)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
34 Bon Secours		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore 29 28-04			
		D. STREET ADDRESS (If rural, give location)			
		224 Stonecroft Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: Hours: Min.
m	w	MARRIED	7-26-10	56	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Executive		Insurance		Baltimore	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
CHARLES Wyatt			Anna Murphy		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No No		214-01-9780		Hospital/Records -	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury at complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
540.01-581.1		(A) Massive GI hemorrhage		1 day	
ANTECEDENT CAUSES		(B) Bleeding peptic ulcer		?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Alcoholic cirrhosis		?	
II		Acute pulmonary edema		1 day	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/12/67 to 6/12/1967, that (I) (we) last saw the deceased alive on 6/12/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Argon Atac				6/12/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Argon Atac		Bon Secours Hosp. Balto, Md		21223	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		June 16 1967		New Cathedral Cemetery	
		24D. LOCATION (City, town, or county)		(State)	
		Old Frederick Rd. Balto. Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 15 1967		R. B. E. Fabela		Theresa J. Henry Inc 1600 Hollins St	



2-250

67 5774

BALTIMORE CITY HEALTH DEPARTMENT

67 5774

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

OTIS H. JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

June 11, 1967

7:50 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

716 Whitmore Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

716 Whitmore Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 11, 1910

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Howard Jackson

14. MOTHER'S MAIDEN NAME

Kalah Doswell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Wynona Jackson Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Adenocarcinoma of sigmoid colon
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 12, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

6-15-67

23C. NAME OF CEMETERY or CREMATORY

Spring Field

23D. LOCATION

(City, town, or county)

(State)

Meherrian, Virginia

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 15 1967

Robert E. Jenkins

Arlington S. Phillips 1727 N. Monroe St.

Wm. H. 1880
Virginia
Robert A. Smith
Superintendent

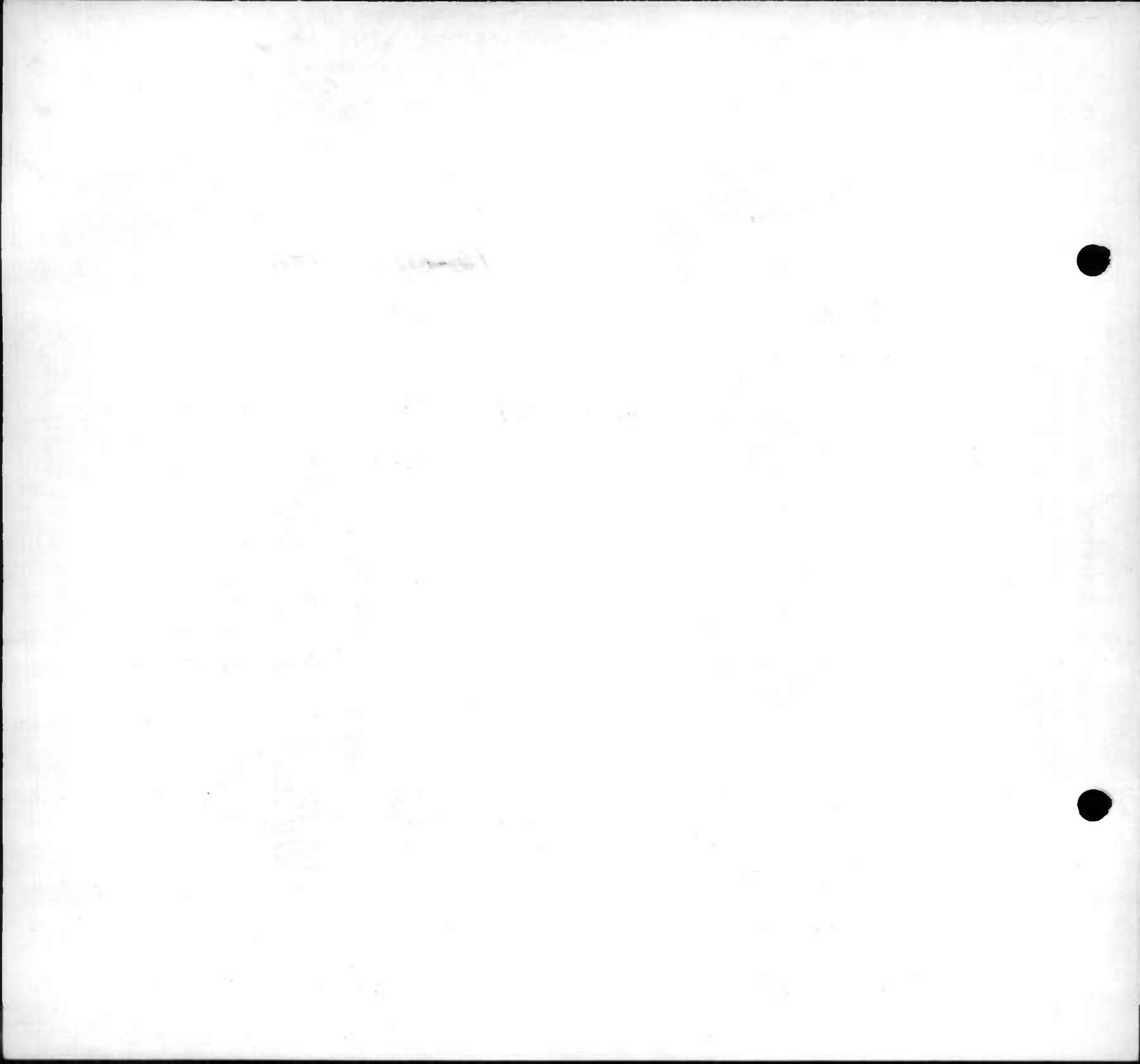
Wm. H. 1880
Virginia
Robert A. Smith
Superintendent

FORGIVE

ATTENT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

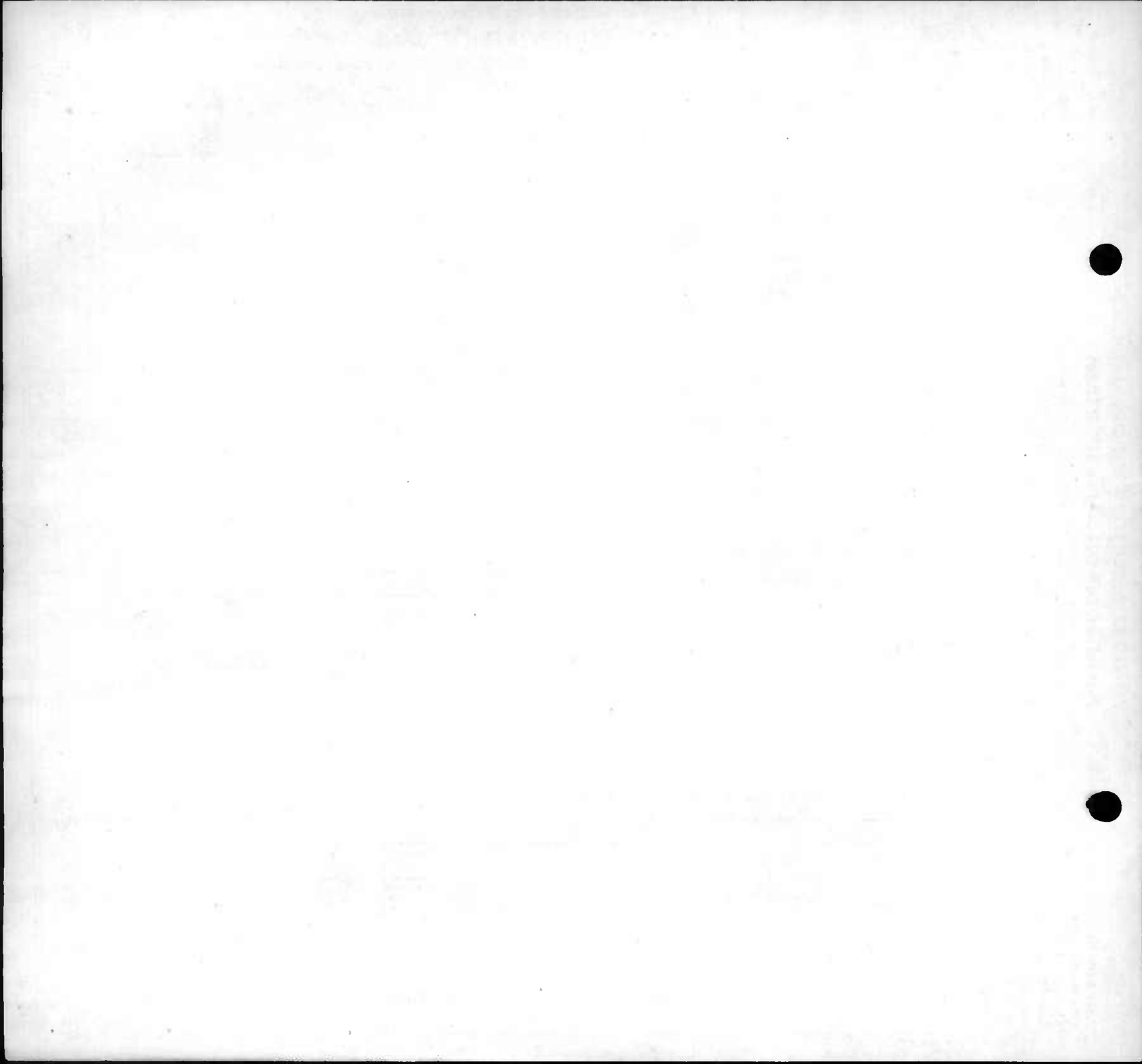
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5775	
BIRTH NO. 150X1		67 5775		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM DAMERON		2. DATE AND HOUR OF DEATH 6/9/67 6:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		D. STREET ADDRESS (If rural, give location)		4212 Evans Chapel Road #21211	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-24-12	9. AGE (In years lost birthday) 54	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-01-3769		17. INFORMANT BGM 4940 Eastern Avenue RECORDS: Baltimore, Maryland #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO CARCINOMA ESOPHAGUS 9 MOS.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/29 19 67 to 6/9 19 67, that (I) (we) last saw the deceased alive on 6/9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jan Shenk		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/9/67	
23C. PHYSICIAN'S NAME (Type) IAN. SHENK		M.D. 23D. ADDRESS 550 N. BROADWAY BALTO., MD. 21205			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6/12/67		24C. NAME of CEMETERY or CREMATORY Clear View	
24D. LOCATION (City, town, or county) Charlestown		24E. (State) Md.		24F. (Zip) 21205	
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1967		25B. NAME OF REGISTRAR Robert E. Fellers		25C. FUNERAL DIRECTOR Address 1727 N. Mount St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5776		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5776	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>ISABELLE J. Hopewell</i>		2. DATE AND HOUR OF DEATH <i>June 11, 1967 7:28 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>2718 Parkwood Ave. Baltimore, md.</i>		D. STREET ADDRESS (If rural, give location) <i>2718 PARKWOOD AVE</i>		13-04	
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>8/3/21</i>	9. AGE (In years last birthday) <i>45</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cashier</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Supermarket</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY <i>USA</i>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>not</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mildred Lewis (sister)</i> ADDRESS <i>same</i>	
18. <i>600.01</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Chronic Pyelonephritis with uremia</i>		<i>6 months</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>none</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>6/11 Feb</i> 19 <i>66</i> to <i>Present</i> , that (I) (was) last saw the deceased alive on <i>6/11</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Stewart, M.D.</i>		23B. DATE SIGNED <i>6/12/67</i>		23C. PHYSICIAN'S NAME (Type) <i>D. W. STEWART</i> M.D.	
23D. ADDRESS <i>3414 Duval Ave.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-15-67</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 15 1967</i>	
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Arlington S. Phillips</i>		ADDRESS <i>1727 N. Monroe St.</i>	



S-363

67 5777

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 5777

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5777		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5777	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John Alfred Stewart		2. DATE AND HOUR OF DEATH 6/10/67 6:05A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4940 Eastern Ave. # 21224			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 7-31-81	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Stewart		14. MOTHER'S MAIDEN NAME Leah Connor	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT BCM: Records 4940 Eastern Ave. Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Tuberculosis (Pulm)		CAUSE OF DEATH (A) Tuberculosis (Pulm) (B) Sepsis (C) UTI		INTERVAL BETWEEN ONSET AND DEATH 15 y. 1 wk. 3 y.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Jaundice		16 wk.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/17 1963 to 6/10 1967 , that (I) (we) last saw the deceased alive on 6/10 1967 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Clayton Moravec		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/10/67	
23C. PHYSICIAN'S NAME (Type) Clayton Moravec		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-14-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 15 1967			
25B. NAME OF REGISTRAR Robert E. Fady...		25C. FUNERAL DIRECTOR'S ADDRESS Arlington S. Phillips 1727 N. Monroe St.			

John Stewart and Son

London (Ind)

1872

James

11/10

0

0

11/10

6/11/67
TROY, ELLIZABETH
Hx # 110 97 97
FUNERAL DIRECTOR: IMPORTANT Dead at 5:40 PM

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5778	
BIRTH NO. 67 5778				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Troy, Elizabeth</i>		2. DATE AND HOUR OF DEATH <i>June 11, 1967 5:40 P.M.</i>	
3. PLACE OF DEATH <i>IN BALTIMORE, MARYLAND</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 THE JOHNS HOPKINS HOSPITAL</i>		D. STREET ADDRESS (If rural, give location) <i>1012 E. NORTH AVE.</i>		9-08	
5. SEX <i>FEMALE</i>	6. RACE <i>NEGROID</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>11-2-25</i>	9. AGE (In years lost birthday) <i>41</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Robert Prosser</i>		14. MOTHER'S MAIDEN NAME <i>Cheryl Goode</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Elvie Johnson Richmond, V.A.</i>	
18. <i>600,014260X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Septic shock</i> (B) <i>Pyelonephritis</i> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes</i>					
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>he</i> (this hospital) attended the deceased from <i>6/11/67</i> 19 to <i>6/11/67</i> 19, that <i>he</i> (we) last saw the deceased alive on <i>6/11/67</i> 19 and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>he</i> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H. R. Gertner, Jr.</i>				23B. DATE SIGNED <i>June 11, 1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. H.R. GERTNER, JR.</i>		23D. ADDRESS M.D. <i>THE JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>6-12-67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Quiransin Cemetery Richmond - Va.</i>	
24D. LOCATION (City, town, or county) (State) <i>Richmond - Va.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 15 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>	
25C. FUNERAL DIRECTOR <i>Edward General Richmond, V.A.</i>		ADDRESS			

9 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

THE
V. M.
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Lighter colored
Photographic plates

Respectfully
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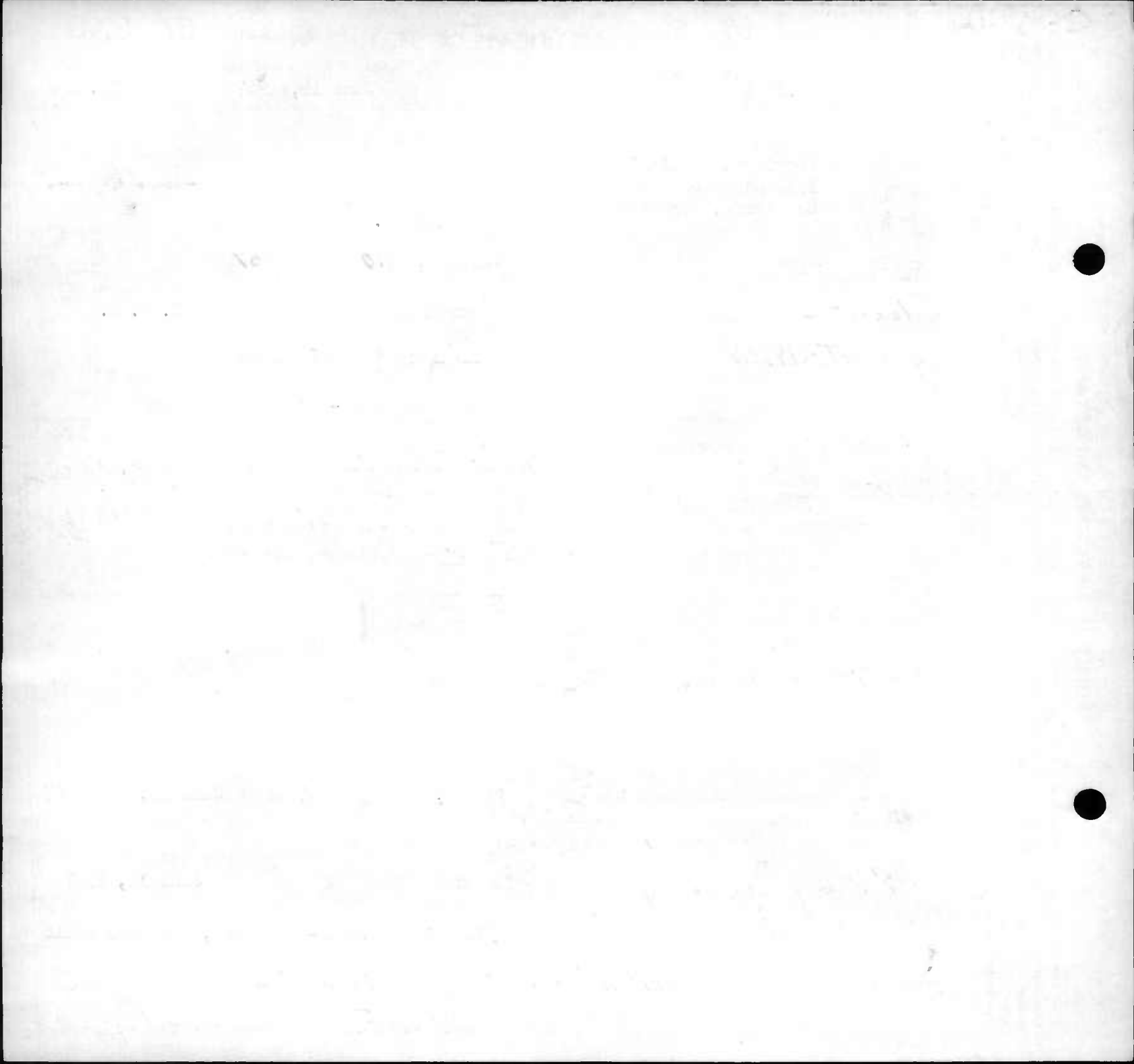
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5779</u>	
BIRTH NO. <u>67 5779</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ATKINSON</u> <u>Lillie Mae Cowan</u>		2. DATE AND HOUR OF DEATH <u>June 14, 1967</u> <u>10:20 a</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>39</u> <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> O. STREET ADDRESS (If rural, give location) <u>1012 W. Lanvale Street</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>March 5, 1910</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>Joe ATKINSON</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Stevens</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Cleodores Cowan-husband</u> ADDRESS <u>same</u>	
18. I <u>172X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>Metastatic Carcinoma, Lungs</u> (B) DUE TO <u>adenocarcinoma of uterus, Endometrium</u> (C)		INTERVAL BETWEEN ONSET AND DEATH <u>approximately 3 years plus</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>9-18-64</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma uterus</u>		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <u>June 7,</u> 19 <u>67</u> to <u>June 14,</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 14,</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Elroy Young,</u> M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>June 14, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>Elroy Young</u>		23D. ADDRESS <u>3200 Elgin Avenue-Baltimore, Maryland 21216</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE		24C. NAME of CEMETERY or CREMATORY <u>Shiloh Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Princeton</u>		24E. LOCATION (State) <u>N.C.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 15 1967</u>		25B. NAME OF REGISTRAR <u>R. E. E. Taylor</u>		25C. FUNERAL DIRECTOR <u>1011-13</u> ADDRESS <u>Suburban Funeral Home - N. Arlington Ave.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5780	
BIRTH NO. 67 5780		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Robinson, David O.		2. DATE AND HOUR OF DEATH 6-13-67 5:57 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. Baltimore, Maryland 21217		A. STATE Maryland B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 716 N. Carey Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH April 1, 1907	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Gas & Elect. Co. Power Company		10B. KIND OF BUSINESS OR INDUSTRY Elec. & Gas		11. BIRTHPLACE (State or foreign country) Goldsboro, North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 212-05-3440		17. INFORMANT Mr. David W. Robinson - 3516 Groveland Ave			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) intractable shock myocardial infarction cardiac failure myocardial irritability		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-12-67 19 to 6-13-67 19, that (I) (we) last saw the deceased alive on 6-13-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE N. Khoda M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/13/67	
23C. PHYSICIAN'S NAME (Type) N. Khoda		23D. ADDRESS 1500 Division St Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/67		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION Arbutus Balto Co. Md		25A. DATE REC'D BY HEALTH DEPT. JUN 15 1967			
25B. NAME OF REGISTRAR Herbert E. Nutter		25C. FUNERAL DIRECTOR ADDRESS 3035 W. North Ave			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5781	
BIRTH NO. 67 5781		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MORGAN, John L.			2. DATE AND HOUR OF DEATH June 13, 1967 3:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 17-01 D. STREET ADDRESS (If rural, give location) 517 W. Biddle Street		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 5/26/15	9. AGE (In years last birthday) 52	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10B. KIND OF BUSINESS OR INDUSTRY Department Store		11. BIRTHPLACE (State or foreign country) Bailey, North Carolina	
13. FATHER'S NAME Joseph Morgan			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6/8/43 - 2/26/46			16. SOCIAL SECURITY NO. 220-04-0664		17. INFORMANT ADDRESS Veterans Administration Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cancer of the pharynx			INTERVAL BETWEEN ONSET AND DEATH 2 Years		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 27th 19 67 to June 13th 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 13th 19 67 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE David N. Marine				23B. DATE SIGNED June 14, 1967	
23C. PHYSICIAN'S NAME (Type) DAVID N. MARINE				23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Blvd., Balto., Md 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/67		24C. NAME OF CEMETERY OR CREMATORY Baltimore National	
24D. LOCATION 5501 Frederick Ave., Balto., Md.		24E. DATE REC'D BY HEALTH DEPT. JUN 15 1967		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. DATE REC'D BY HEALTH DEPT. JUN 15 1967		24H. NAME OF REGISTRAR Robert E. Taylor		24I. FUNERAL DIRECTOR ADDRESS 5501 Frederick Ave., Balto., Md.	

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BIRTH NO. 67. 5782		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) MILTON MOORE		2. DATE AND HOUR PRONOUNCED DEAD 6-13-67 7:00 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2240 DRUID HILL AVENUE - Amb. Crew #4		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2240 Druidhill Avenue	
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH March 7-1909
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious		10B. KIND OF BUSINESS OR INDUSTRY Religious	9. AGE (In years last birthday) 58
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert A. Moore		14. MOTHER'S MAIDEN NAME Mary Walker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-3486	
17. INFORMANT Dorothy Moore		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, or asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6-16-67	
23C. NAME OF CEMETERY or CREMATORY Mt Auburn Cmt		23D. LOCATION (City, town, or county) (State) Baltimore Md	
24A. DATE REC'D BY HEALTH DEPT. JUN 15 1967		24B. NAME OF REGISTRAR Robert E. Fisher	
		24C. FUNERAL DIRECTOR Joseph W. Fisher	
		ADDRESS Baltimore Md	

VALLEY VIEW
SOUTHERN POWER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67, 5783	
67, 5783				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) ALLEN LEWIS MILES		JUNE 13, 1967 8:00 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		A. STATE MARYLAND B. COUNTY 12-04			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2234 BARCLAY ST.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 06-10-10	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME John Henry Miles		14. MOTHER'S MAIDEN NAME MANZY BARNES		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. DITHUR MILES ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 443X1177X (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Cerebrovascular Accident DUE TO (B) Hypertensive arteriosclerosis DUE TO (C) Cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 8 days ? years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of the Prostate			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>JUNE 6, 1967</u> to <u>JUNE 13, 1967</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>JUNE 13, 1967</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> view the body after death.					
23A. SIGNATURE James W. Carty Jr.				23B. DATE SIGNED 6/13/67	
23C. PHYSICIAN'S NAME (Type) JAMES W. CARTY JR.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/17/67		24C. NAME OF CEMETERY or CREMATORY Burlington	
24D. LOCATION (City, town, or county) North Carolina		24E. STATE (State) North Carolina			
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1967		25B. NAME OF REGISTRAR Robert E. Farberman		25C. FUNERAL DIRECTOR Adolphus Helstead ADDRESS 1206 W North Ave	

THE UNIVERSITY OF CHICAGO

CHICAGO, ILL.

W. 325

67 5784

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5784

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
JOHN WATSON		6-12-67 4:35 PM _{M.}	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland	
SINAI HOSPITAL - DOA		B. COUNTY Baltimore	
5. SEX		6. RACE	
Male	Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH		9. AGE (In years last birthday)	
8-6-17		49 ?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
		S.C.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
S.C.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Alonzo Watson		Elizabeth McMorris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		212140886	
17. INFORMANT		ADDRESS	
Mamie Wingale		10 W 135th St. N. Y. C.	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			
(A) Subarachnoid hemorrhage DUE TO			
(B) Ruptured Berry aneurysm DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2			
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
RUSSELL S. FISHER, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	
Burial		6-16-67	
23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Baltimore Nat'l. Cem.		Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	
JUN 15 1967		Robert E. Fisher, M.D.	
24C. FUNERAL DIRECTOR		ADDRESS	
Kelson Funeral Home		1348 Calhoun St.	

1 9 6 7 6 0 0 5 7 9 4

WALLACE JOHNSON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5785	
BIRTH NO. 67 5785		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH (BOR) June 14, 1967 12:05 Am.			
1. NAME OF DECEASED (Type or Print) Dorsey, James E.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1522 N. Mount Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-30-00	9. AGE (In years last birthday) 67 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Dorsey		14. MOTHER'S MAIDEN NAME Mamie Scott	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-03-3282-A		17. INFORMANT ADDRESS Helen Dorsey 1522 Mount St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema Acute Congestive Heart Failure		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Hemorrhagic C.V.A.		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 13, 1967 to June 14, 1967 , that (I) (we) last saw the deceased alive on June 14, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lizarazo		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-14-67	
23C. PHYSICIAN'S NAME (Type) Lizarazo		23D. ADDRESS 1514 Division Street Balto., Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-19-67		24C. NAME of CEMETERY or CREMATORY Baltimore Nat'l. Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Kelson Funeral Home 1348 Calhoun St.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5786	
BIRTH NO. 67 5786		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Loretta Jones		2. DATE AND HOUR OF DEATH 6/12/67 1 10 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Bolton Hill Nursing + Convalescent Home		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1802 N. Carey Street			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 10/24/34	9. AGE (In years last birthday) 33	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME James Fowler			14. MOTHER'S MAIDEN NAME Elizabeth Gray		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Charlee Williams 1802 N. Carey St.	
18. 332X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBRAL THROMBOSIS		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-4 19 67 to 6/12 19 67 , that (I) (we) last saw the deceased alive on 6-12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Horris Dean Arline M.D.				23B. DATE SIGNED 6/14/67	
23C. PHYSICIAN'S NAME (Type) Horris Dean Arline		23D. ADDRESS 930 W. IZACK ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-16-67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS Kelson Funeral Home 1348 N. Calhoun	

(See also the end of the book)

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the end of the book

John G. Thompson
1942

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67 5787

BALTIMORE CITY HEALTH DEPARTMENT

67 5787

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANK G. SCIESZKA

2. DATE AND HOUR PRONOUNCED DEAD

6-13-67

6:00 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CHURCH HOME AND HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

511 S. Chapel Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

1-13-1912

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SHIP SEALER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

GEORGIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN SCIESZKA

14. MOTHER'S MAIDEN NAME

MARY ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

218-01-3631

17. INFORMANT

ADDRESS

LILLIAN SCIESZKA 511 S. CHAPEL ST.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

Russell S. Fisher

M.D.

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S

NAME (Type) RUSSELL S. FISHER, M.D.

6-14-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

6-17-1967

23C. NAME of CEMETERY or CREMATORY

GARDENS OF FAITH

23D. LOCATION

BALTO

(City, town, or county)

(State)

MARYLAND

24A. DATE REC'D. BY HEALTH DEPT.

JUN 15 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

JOHN M. WEBER & SONS INC. 4015 CHESTER ST.

1-13-1914

MARKED

1-13

1-13-1914

SHIP BOARD

MARY

JOHN SCIESKA

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NY

MARY

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NY

THE NEW YORK PUBLIC LIBRARY

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5788					REGISTERED NO. 67 5788				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Roy Galen Spiker					2. DATE AND HOUR OF DEATH June 13, 1967 6:55 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital 3100 Wyman Pk. Drive					4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY Allegany Co.				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Lonaconing				
					D. STREET ADDRESS (If rural, give location) 248 Charlestown St.				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 1/28/45	9. AGE (In years last birthday) 22	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Andrew Spiker					14. MOTHER'S MAIDEN NAME Iva Beeman				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) none			16. SOCIAL SECURITY NO. 219-44-0319		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Hodgkin's disease (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)					INTERVAL BETWEEN ONSET AND DEATH Years				
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from Apr. 20 1967 to June 13 1967 , that (1) (we) last saw the deceased alive on June 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.									
23A. SIGNATURE Michael E. Pelczar M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6/13/67	
23C. PHYSICIAN'S NAME (Type) Michael E. Pelczar, SA Surg (R) M.D.					23D. ADDRESS US PHS Hospital, Balto, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/1967		24C. NAME OF CEMETERY OR CREMATORY Beemens Cemetery		24D. LOCATION (City, town, or county) (State) Lonaconing, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1967			25B. NAME OF REGISTRAR Robert E. Falsman		25C. FUNERAL DIRECTOR George Eichhorn		ADDRESS Lonaconing, Md.		

Michael S. Velez

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5789					67 5789				
BIRTH NO.					REGISTERED NO.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) BERTHA M HUTCHINS (Hutchens)					2. DATE AND HOUR OF DEATH 6 11 67 7:30 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balts. Co				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL WILKENS & CATON BALTO 29 MD					C. CITY OR TOWN (If outside city limits, write RURAL and give township) LANSDOWNE 21227				
D. STREET ADDRESS (If rural, give location) 402 FIFTH AVENUE									
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 04 18 83	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWFE			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Thomas					14. MOTHER'S MAIDEN NAME SUSAN Thomas				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214 54 9477		17. INFORMANT ADDRESS ST AGNES HOSPITAL RECORDS				
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Embolism									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					Acute Hemorrhagic Pancreatitis				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6 9 1967 to 6 11 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6 11 19 67 and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.									
23A. SIGNATURE C. Del Rosario					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6 11 67		
23C. PHYSICIAN'S NAME (Type) C. DEL ROSARIO,					23D. ADDRESS WILKENS & CATON AVES. ST. AGNES HOSPITAL-BALTO., MD. 21229				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 14, 1967		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1967			25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS G. Truman Schwab 3512 Frederick Ave. Balto. Md.				

To: Mr. E.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5790	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 5790 CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) GEORGE C. BUSSARD			2. DATE AND HOUR OF DEATH 6-12-67 12:10 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 29, MARYLAND </div> <div> 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN If outside city limits, write RURAL and give township BALTIMORE D. STREET ADDRESS (If rural, give location) 102 S. LOUDON AVENUE </div> </div>					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-2-02	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-FIRE DEPT.		10B. KIND OF BUSINESS OR INDUSTRY BALTO. CITY FIRE DEPT.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME DEC'D William E. Bussard		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW1			16. SOCIAL SECURITY NO. 212-34-5736		
17. INFORMANT DEC'D Emma Schaefer			ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (A) DUE TO MYOCARDIAL INFARCTION (B) DUE TO CORONARY THROMBOSIS (C) </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNOERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 5 19 67 to JUNE 12 19 67, that (I) (we) last saw the deceased alive on JUNE 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Edwards</i>				23B. DATE SIGNED 6/12/67	
23C. PHYSICIAN'S NAME (Type) C. POLLICINA				23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
24A. BURIAL REMOVAL (Specify) Burial		24B. DATE June 15, 1967		24C. NAME OF CEMETERY or CREMATORY Lakeview Cem.	
24D. LOCATION (City, town, or county) (State) Randallstown Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 15 1967			
25B. NAME OF REGISTRAR R. B. E. / J. E. B.		25C. FUNERAL DIRECTOR G. B. Schwan			
ADDRESS 3512 Frederick Ave. Balto. Md.					

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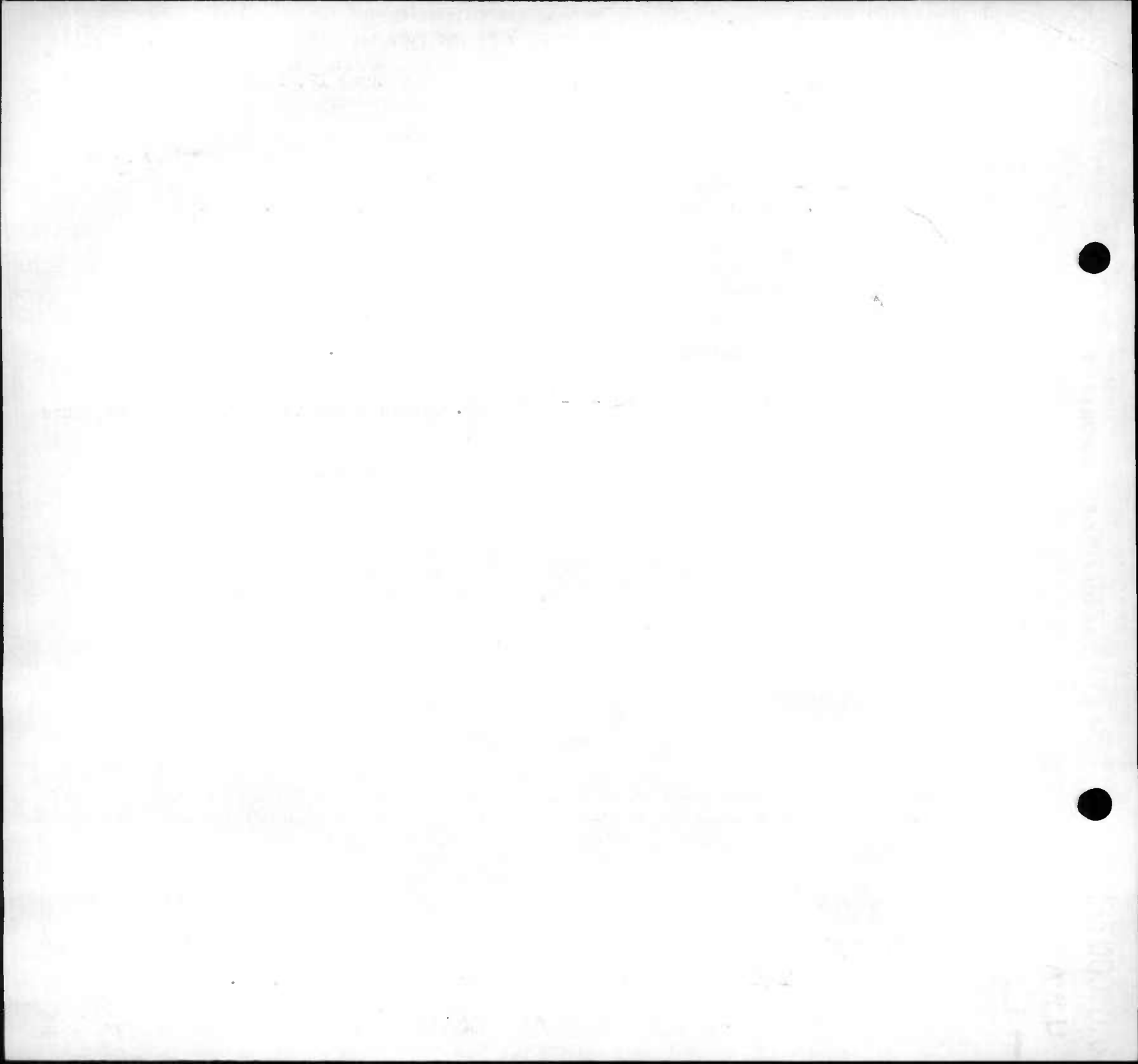
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

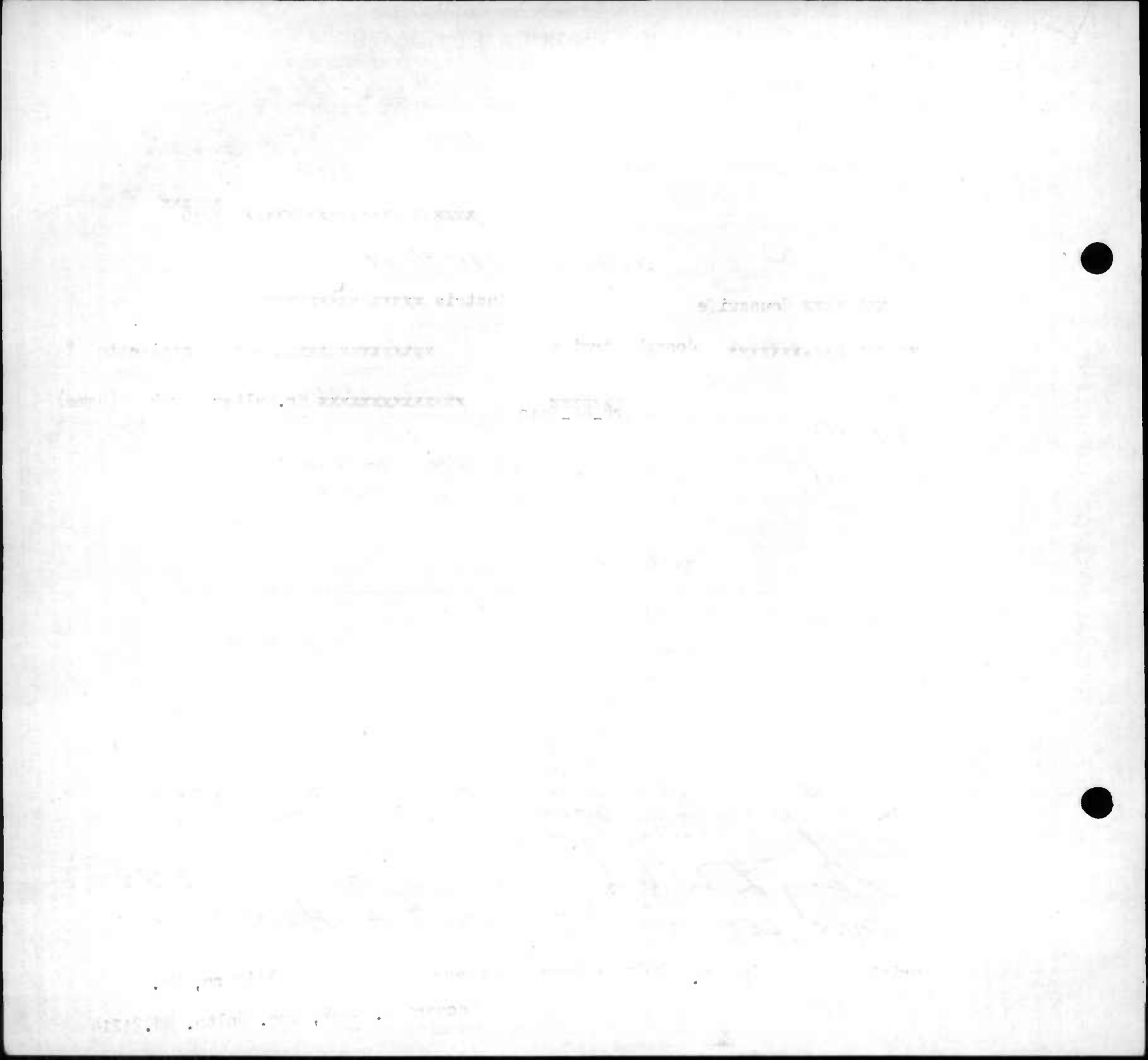
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5791</u>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>67 5791</u> CERTIFICATE OF DEATH </div>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>Sarah Maud Stone</u>			2. DATE AND HOUR OF DEATH <u>June 12, 1967</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Bar-Wil-Ba Nursing Home</u> <u>2101 W. Cold Spring Lane</u>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
			D. STREET ADDRESS (If rural, give location) <u>5300 Ethelbert Ave.</u> <u>15</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 19, 1877</u>	9. AGE (In years last birthday) <u>90</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Hartzell</u>			14. MOTHER'S MAIDEN NAME <u>Fannie L.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-01-3037 A</u>		17. INFORMANT ADDRESS <u>Mr. Gordon Wareheim same address as above</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>420.0 I</u> (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic heart disease</u> DUE TO <u>Generalized arteriosclerosis</u> DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5-10-</u> <u>1967</u> to <u>6-12-</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>6-12-</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C.R. Campbell</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>6-13-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>C.R. Campbell</u>		23D. ADDRESS M.D. <u>1618 W. North Ave. Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/15/1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 15 1967</u>		25B. NAME OF REGISTRAR <u>Wm. E. Feltner</u>		25C. FUNERAL DIRECTOR <u>Wm. E. Feltner</u>	
ADDRESS <u>Baltimore, Md.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5792</u>	
BIRTH NO. <u>67 5792</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH <u>6-14-67 8:35 AM</u>	
1. NAME OF DECEASED (Type or Print) <u>MARYanna NOVAK</u>				M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 MARYLAND GEN. HOSP</u>				A. STATE <u>MD.</u>	
				B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO. 21206</u>	
				D. STREET ADDRESS (If rural, give location) <u>4800 BELAIR RD. 5210</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>11-21-84</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Joseph Strcilo</u>			14. MOTHER'S MAIDEN NAME <u>Antoinette ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-44-8012</u>		
			17. INFORMANT ADDRESS <u>Mr. Walter Novak (Same)</u>		
18. <u>175.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>OVARIAN CARCINOMA WITH METASTASIS</u>				INTERVAL BETWEEN ONSET AND DEATH	
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>No</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that <u>us</u> (this hospital) attended the deceased from <u>5-27</u> 19 <u>67</u> to <u>6-14</u> 19 <u>67</u> , that <u>us</u> (we) last saw the deceased alive on <u>6-14</u> 19 <u>67</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>us</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Larry L. Label</u>				23B. DATE SIGNED <u>6-14-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>GARY LEE NOBEL</u>				23D. ADDRESS <u>2903-A ANDORRA BALTO MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/17/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 15 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 5793

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 5793

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				BILLINGSLEY, JOHN MAURICE		JUNE 15, 1967 8:05 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
27 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218				MARYLAND DELETED			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE 21213			
				D. STREET ADDRESS (If rural, give location)			
				3215 LAWNVIEW AVENUE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
MALE	CAUCASIAN	MARRIED		1-20-1890	77		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Carpenter						MARYLAND	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JAMES M. BILLINGSLEY				IDA VIRGINIA HENRY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES 7-20-18 to 12-9-18				216-03-59-13A		VETERANS HOSPITAL RECORDS 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES				2 years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				MANY YEARS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				5 Days			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from JUNE 8 19 67 to JUNE 15 19 67, that (X) (we) last saw the deceased alive on JUNE 15 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Allen Johnson						June 15, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ALLEN D. JOHNSON, M.D.				VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/19/67		Gardens of Faith Cemetery		Baltimore, Md.	
25A. DATE REC'D IN HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 15 1967		Robert E. Fairley		Leonard J. Rueck, Inc. Balto. Md. 21214			

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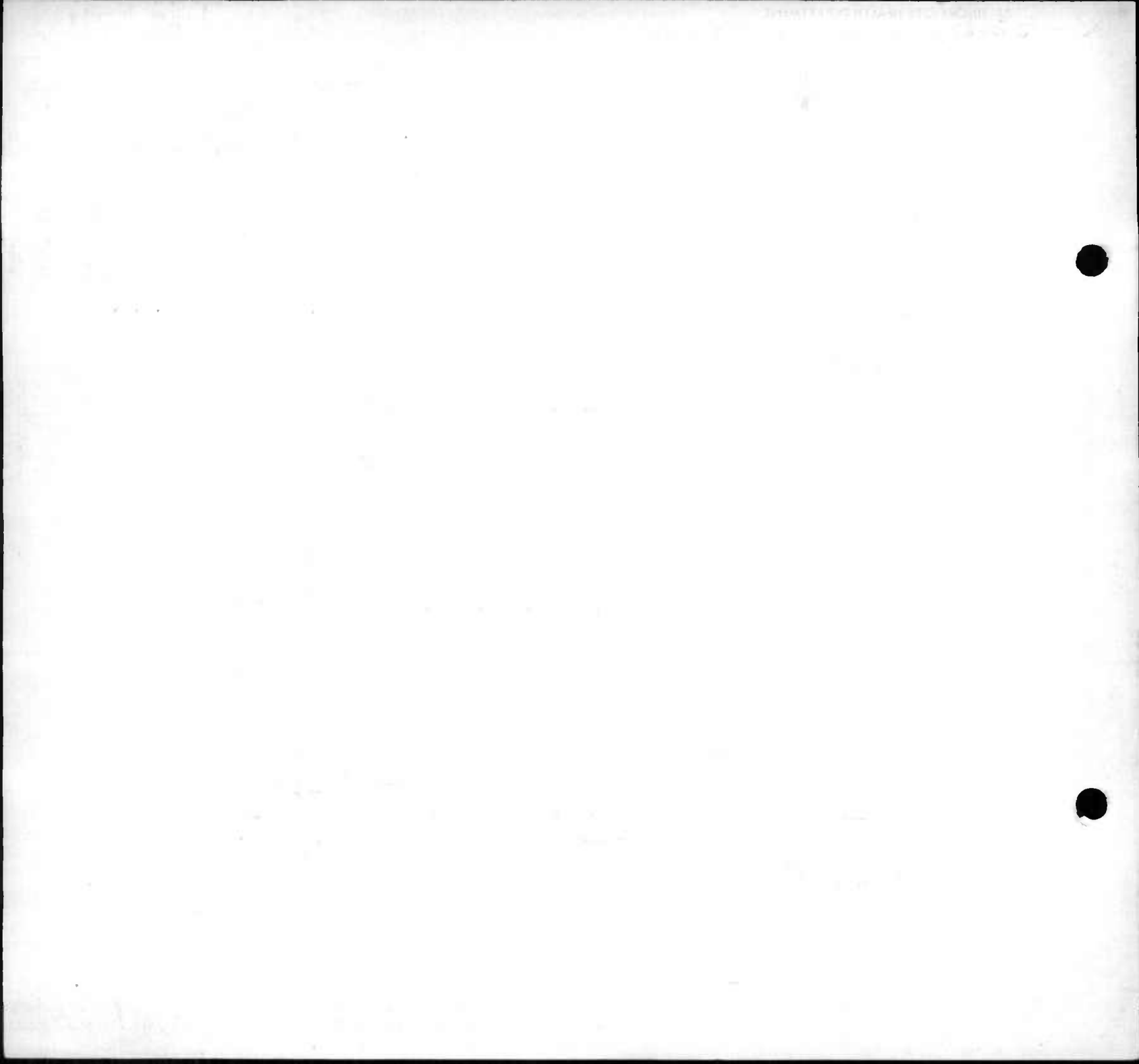
2006-2007

2008-2009

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5794	
67 5794				67 5794	
CERTIFICATE OF DEATH				67 5794	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Gertrude Young	
2. DATE AND HOUR OF DEATH		6-13-1967 10:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
90 Gould Convalesorium Belair Road		Md. 26-01			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Female		White		Married	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY?	
3/26/1888		79		U.S.A.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Stewartstown PA.		U.S.A.		John H Grove	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Sarah A Gibbs		No		217-38-4282	
17. INFORMANT		ADDRESS 21206			
Mr Robert Lee Young		4408 Bayonne Avenue			
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
(A) DUE TO Carcinoma of Breast with Metastases		many years			
(B) DUE TO					
(C) DUE TO					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Hypertensive Cardiovascular Disease many years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 05-19-46 to 6-13-1967, that (I) (we) last saw the deceased alive on 6-6-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Max R. English M.D.				23B. DATE SIGNED 6-15-67	
23C. PHYSICIAN'S NAME (Type) Max R. English M.D.				23D. ADDRESS 5743 Belair Rd Baltimore, Md. 21206	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6-16-1967		Loudon Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 18 1967		Robert E. Johnson		Joseph Funeral Home 7401 Belair Road	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5795					REGISTERED NO. 67 5795				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) <i>Dolores A. Kugelmann</i>					2. DATE AND HOUR OF DEATH <i>June 13, 1967 3:05 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 Bon Secours Hospital</i>					4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTO. Co.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTO.</i> D. STREET ADDRESS (If rural, give location) <i>355 Greenlow Rd 53-00</i>				
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <i>11/22/96</i>	9. AGE (In years last birthday) <i>70</i>	10. If Under 1 Yr. Months: Days: Hours: Min.		11. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Hunt</i>				14. MOTHER'S MAIDEN NAME <i>Theresa ? Cecil</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>WILLIAM H KUGELMAN</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>5-85X</i>				CAUSE OF DEATH (A) <i>Duodenal fistula with bile peritonitis</i> (B) <i>Status post 20 days cholecystectomy + invagination of duodenal diverticulum</i> (C)				INTERVAL BETWEEN ONSET AND DEATH <i>20 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<i>Electrolyte imbalance + shock</i>				<i>15 days</i>	
19A. DATE OF OPERATION <i>5-24-67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Acute cholecystitis + diverticulum of duodenum</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>5-16-1967</i> to <i>6-13-67</i> 19 <i>67</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>6-13</i> 19 <i>67</i> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did not) view the body after death.									
23A. SIGNATURE <i>Jorge B. Joaquin</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>June 13, 1967</i>		
23C. PHYSICIAN'S NAME (Type) <i>JORGE B. JOAQUINO</i>					23D. ADDRESS <i>Bon Secours Hospital Baltimore, Maryland 21223</i>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
<i>BURIAL</i>		<i>JUNE 16 1967</i>		<i>NEW CATHEDRAL</i>		<i>BALTIMORE MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 16 1967</i>		25B. NAME OF REGISTRAR <i>ROBERT E. Taylor</i>		25C. FUNERAL DIRECTOR <i>6601 FREDERICK AVE FARLEY B. CAYANAUGH HOME</i>					

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BALTIMORE CITY HEALTH DEPARTMENT									
67 5796 CERTIFICATE OF DEATH					Registered No. 67 5796				
1. NAME OF DECEASED (Type or Print) <u>Hall, James Alfred</u>					2. DATE AND HOUR OF DEATH <u>6-14-67</u> <u>3:15 A.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u>					A. STATE <u>Md.</u> B. COUNTY <u>BALTIMORE Co.</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>22 DUNDALK</u>				
					D. STREET ADDRESS (If rural, give location) <u>79 Dundalk Ave</u> <u>53-00</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>6/22/11</u>	9. AGE (In years lost birthday) <u>55</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFR</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Hall, James Alfred</u>					14. MOTHER'S MAIDEN NAME <u>Webb.</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no [unknown]) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>213-07-7078</u>		17. INFORMANT <u>Admission Sheet</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>420.11</u>					CAUSE OF DEATH (A) DUE TO <u>MYOCARDIAL INFARCTION</u> (B) DUE TO <u>CORONARY Occlusion</u> (C) DUE TO <u>A.S.C.V.D.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u> <u>DAYS</u> <u>YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>JUNE 2</u> 19 <u>67</u> to <u>JUNE 14</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>JUNE 14</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Agustin del Campo</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>JUNE 14 -1967</u>		
23C. PHYSICIAN'S NAME (Type) <u>AGUSTIN del CAMPO</u> M.D.					23D. ADDRESS <u>BON-SECOURS Hosp. BALT. 21223 Md</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/17/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>OAK LAWN</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. Co. Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 16 1967</u>			25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>W. Brooks Bradley</u>		ADDRESS <u>445B</u>		

B-532

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT										
67 5797					Registered No. 67 5797					
BIRTH NO.										
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) <i>Andrew Bandy</i>					2. DATE AND HOUR OF DEATH <i>6/14/67</i> <i>7 P</i> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i> (If not in hospital or institution, give street address or location)					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1105 Steelton Avenue 21224</i>					
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Divorced</i>		8. DATE OF BIRTH <i>9-5-1904</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto Mechanic</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Ret. Houseing Authority</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John Bandy</i>					14. MOTHER'S MAIDEN NAME <i>Barbara Vokolek</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>219-07-2368</i>		17. INFORMANT <i>Mrs Theresa Coleman</i>			ADDRESS <i>5585 Whitby Road 21206</i>		
18. I <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Cerebrovascular Thrombosis</i> DUE TO (B) DUE TO (C) <i>ASCVD</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <i>None</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>6/13</i> 19 <i>67</i> to <i>6/14</i> 19 <i>67</i> . that (I) (we) last saw the deceased alive on <i>6/14</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>John E. Dranger</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>6/14/67</i>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-17-1967</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore City Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 16 1967</i>			25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i>			25C. FUNERAL DIRECTOR <i>Kessiah F. Home</i>			ADDRESS <i>7401 Belair Rd</i>	

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ASCVD

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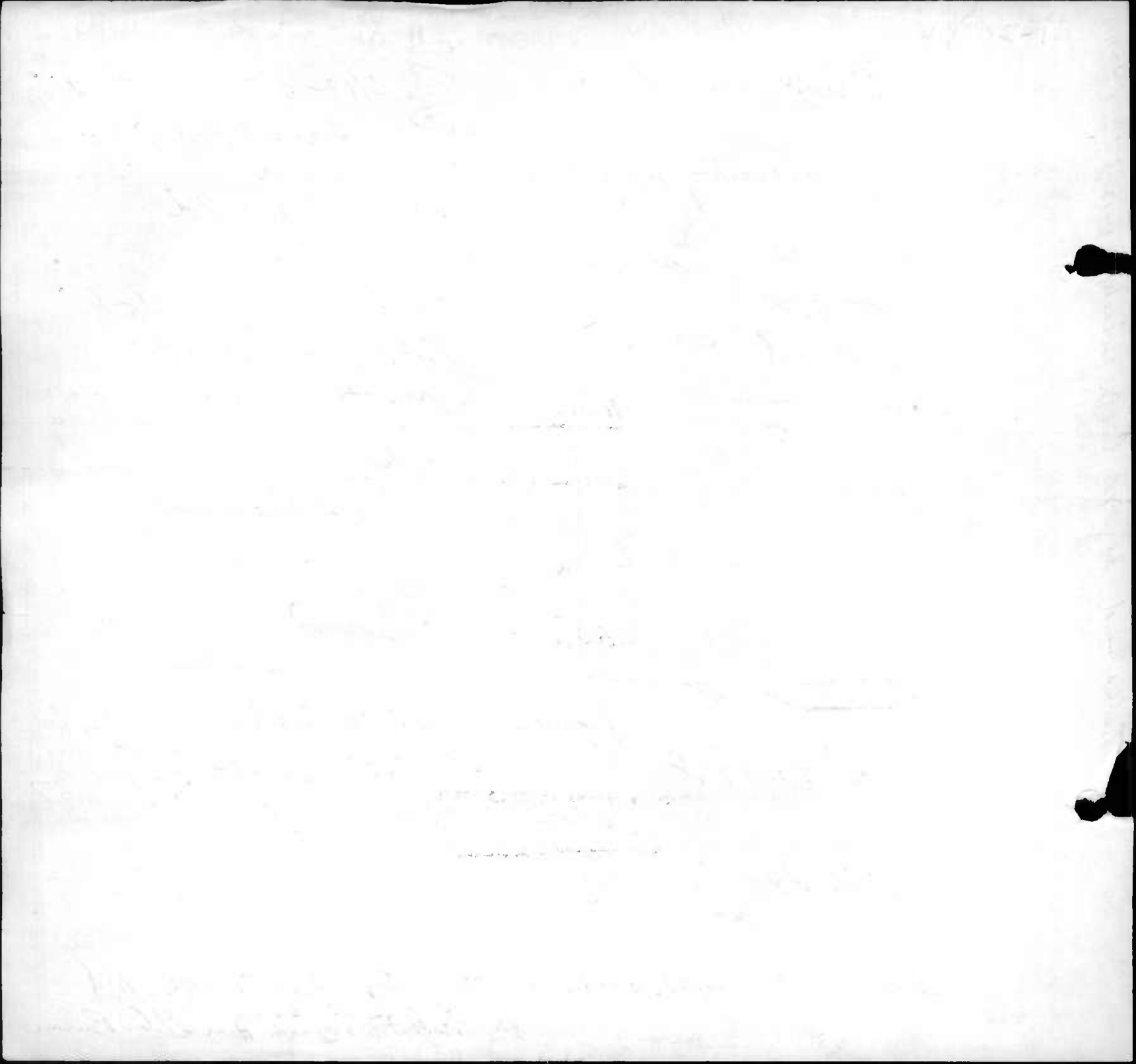
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Released by M. E. (on parish) 6-12-67 1 45 AM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5798		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5798	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Suzanne Mace</i>		2. DATE AND HOUR OF DEATH <i>6/12/67</i> <i>1 45 a</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>Anne Arundel Co.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Glen Burnie</i> <i>52-00</i>			
		D. STREET ADDRESS (If rural, give location) <i>200 Dafodil Rd</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>single</i>	8. DATE OF BIRTH <i>4/3/60</i>	9. AGE (In years last birthday) <i>7</i>	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>student</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>md.</i>	
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		13. FATHER'S NAME <i>DAVID Mace</i>		14. MOTHER'S MAIDEN NAME <i>BARBARA Semaites</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Matter</i> ADDRESS <i>Same as above</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>E916.D</i>		CAUSE OF DEATH <i>Pneumonia</i> <i>Aspiration</i> <i>Extensive second and third degree burns</i> <i>depressed level of consciousness</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		MEDICAL EXAMINER: CHIEF (OR ASST.) <i>[Signature]</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>none</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>6:55 PM</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>at 200 Dafodil Rd Glen Burnie</i>	
21D. TIME OF INJURY (APPROX.) <i>5/22/67</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>in kitchen</i> <i>clothes caught on fire</i>	
22. I certify that (1) (this hospital) attended the deceased from <i>5/22</i> 19 <i>67</i> to <i>6/12</i> 19 <i>67</i> , and that (2) (we) last saw the deceased alive on <i>6/12</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert E. Fink</i> M.D.				23B. DATE SIGNED <i>6/12/67</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>June 24 1967</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Garden of Faith Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, md</i>		24E. STATE <i>md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 16 1967</i>	
25B. NAME OF REGISTRAR <i>Robert E. Fink</i>		25C. FUNERAL DIRECTOR <i>Eugene B. Fleming</i> <i>Sigourney F. French</i> <i>Helen E. Glen Burnie</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

2-4612		67 5799		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5799	
1. NAME OF DECEASED (Type or Print) ZELLERS, VELMIE L.				2. DATE AND HOUR OF DEATH JUNE 13, 1967 6:00 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) JESSUP D. STREET ADDRESS (If rural, give location) 63-00 6 SHAREWOOD DRIVE			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-27-96	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLASS CUTTER			10B. KIND OF BUSINESS OR INDUSTRY Pipe Co. Jessup, Md		11. BIRTHPLACE (State or foreign country) JEANETTE, PENNSYLVANIA		
12. CITIZEN OF WHAT COUNTRY? UNITED STATES			13. FATHER'S NAME LOUIS ZELLERS				
14. MOTHER'S MAIDEN NAME FLORENCE BOUCHER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 7/4/17-1/22/19				
16. SOCIAL SECURITY NO. 389-20-73-20			17. INFORMANT VETERANS HOSPITAL RECORDS ADDRESS 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION, ACUTE CHRONIC OBSTRUCTIVE PULMONARY DISEASE				INTERVAL BETWEEN ONSET AND DEATH 0			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC VASCULAR DISEASE				5 yrs			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. AORTIC ANEURYSM, GRAFTED 1965				5 yrs			
21. DATE OF OPERATION 0				22. CONDITION FOR WHICH OPERATION WAS PERFORMED		23. AUTOPSY? (Yes or No) NO	
24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
27. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		28. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		29. HOW DID INJURY OCCUR?			
30. I certify that 01 (this hospital) attended the deceased from JUNE 9 1967 to JUNE 13 1967 , that 01 (we) last saw the deceased alive on JUNE 13 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. 01 (We) (did) 00000 view the body after death.							
31. SIGNATURE Edward O. Hunt, MD				32. DATE SIGNED JUNE 13, 1967		33. PHYSICIAN'S NAME (Type) EDWARD O. HUNT, MD	
34. ADDRESS VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218				35. BURIAL CREMATION, REMOVAL (Specify) Burial			
36. DATE REC'D BY JUN 16 1967		37. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park		38. LOCATION Elkridge		39. STATE Maryland	
40. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Md.				41. ADDRESS 63-00 6 SHAREWOOD DRIVE			

RECEIVED

DEPT. OF STATE

U.S. DEPARTMENT OF STATE
WASHINGTON, D.C. 20520

OFFICE OF THE SECRETARY

ATTENTION: SECRETARY

RECEIVED

DEPT. OF STATE

U.S. DEPARTMENT OF STATE
WASHINGTON, D.C. 20520

OFFICE OF THE SECRETARY

ATTENTION: SECRETARY

U.S. DEPARTMENT OF STATE

WASHINGTON, D.C. 20520

OFFICE OF THE SECRETARY

ATTENTION: SECRETARY

RECEIVED

DEPT. OF STATE

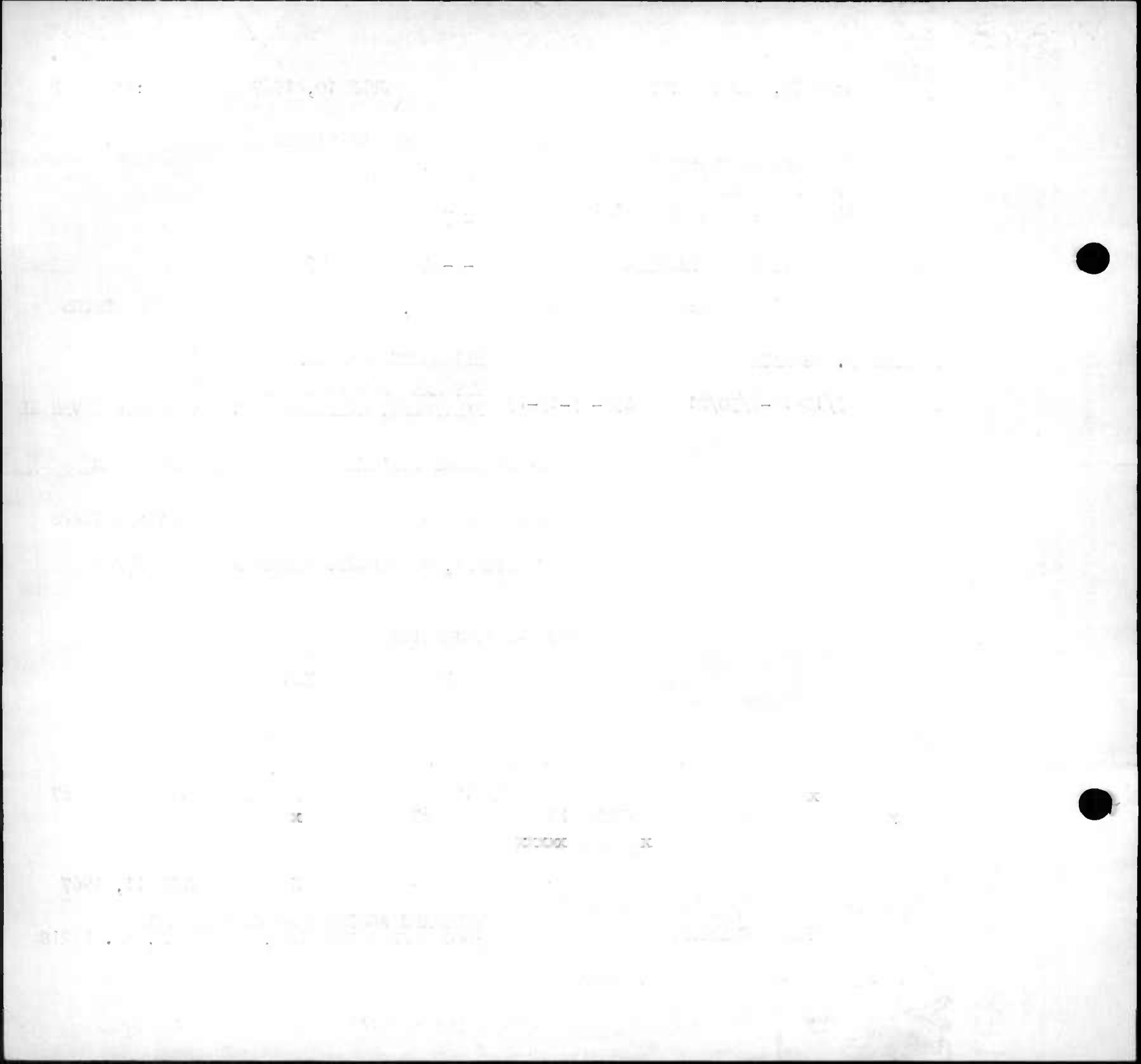
U.S. DEPARTMENT OF STATE

WASHINGTON, D.C. 20520

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5800	
67 5800				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) McGRATH, FRANK HENRY		JUNE 10, 1967 4:45 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218			A. STATE MARYLAND B. COUNTY BALTIMORE Co.		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) LUTHERVILLE			D. STREET ADDRESS (If rural, give location) 207 MEADOWVALE ROAD		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-3-94	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUDITOR		10B. KIND OF BUSINESS OR INDUSTRY KENNECOTT CORP.		11. BIRTHPLACE (State or foreign country) SAMBORN, IOWA	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES			13. FATHER'S NAME PATRICK H. McGRATH		
14. MOTHER'S MAIDEN NAME ELIZABETH SULLIVAN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 5/10/18-9/30/21		
16. SOCIAL SECURITY NO. 453-05-15-15			17. INFORMANT ADDRESS VETERANS HOSPITAL RECORDS BALTIMORE, MARYLAND 21218 3900 LOCH RAVEN BL		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) RIGHT HEART FAILURE			INTERVAL BETWEEN ONSET AND DEATH SIX MONTHS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. GOR PULMONALE			DUE TO SEVERAL YEARS		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. C CARCINOMA RIGHT LUNG			DUE TO TWO YEARS		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 17 19 67 to JUNE 10 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 10 19 67 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) not view the body after death.					
23A. SIGNATURE CRILE CRISLER				23B. DATE SIGNED JUNE 11, 1967	
23C. PHYSICIAN'S NAME (Type) CRILE CRISLER				23D. ADDRESS VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD, BALTIMORE, MD, 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/14/67		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL	
24D. LOCATION (City, town, or county) (State) CATONSVILLE MD.		25A. DATE REC'D BY HEALTH DEPT. JUN 16 1967		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR John B. Jones		25D. ADDRESS Lawson			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5801		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5801	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) TRIBBLE BESSIE M.		2. DATE AND HOUR OF DEATH 6/12 67 8:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore, Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 18-03	
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hosp		D. STREET ADDRESS (If rural, give location) 535 W. Lombard			
5. SEX Female	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 6/20/63	9. AGE (In years last birthday) 4	10. AGE (In years last birthday) 4
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Willie Martin		14. MOTHER'S MAIDEN NAME Martha J. Garrett	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 223-16-5765		17. INFORMANT John Muller - 535 W. Lombard St.	
18. 420.1 I		CAUSE OF DEATH Cardiac Arrest		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO ASCVD - Myocardial Infarction			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/25 19 67 to 6/12 19 67 , that (we) last saw the deceased alive on 6/12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Kurt P. Sligar		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/12	
23C. PHYSICIAN'S NAME (Type) KURT P. SLIGAR		23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/15/67		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem.	
24D. LOCATION (City, town, or county) (State) Glen Burnie Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 16 1967		25B. NAME OF REGISTRAR Robert E. Tabor	
25C. FUNERAL DIRECTOR John J. Cavan		25D. ADDRESS 901 S. Hollers			

7.
The first of the
year

48-80-97th

C-216

67 5802

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 5802

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HENRY CASPARE

2. DATE AND HOUR OF DEATH

6-14-67 1:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1101 TRAVERS WAY 21224

26-36

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

9-23-06 1906

9. AGE (In years
lost birthday)

XX 60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Security guard

10B. KIND OF BUSINESS OR INDUSTRY

Morris Co

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

HENRY Caspare

14. MOTHER'S MAIDEN NAME

JENNIE SMITH

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.
217-0148247

17. INFORMANT

ADDRESS

BCH: RECORDS 4940 EASTERN AVE. 21224

18. 260X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Septic Hypotension

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

Pneumonia

~ 1 wk

(C) DUE TO

Urinary Infection, Cellulitis

3 mos

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus & obesity

many
years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

3/31 & 4/13/67

diabetic foot

Yes

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from 5-3 1967 to 6-14 1967,
that (H) (we) last saw the deceased alive on 6-14 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

James J. Corkins

M.D.

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

6/14/67

23C. PHYSICIAN'S
NAME (Type)

DR. JAMES T. CORKINS

M.D.

23D. ADDRESS

BALTIMORE CITY HOSPITALS
4940 EASTERN AVE. BALTO. MD. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-17-67

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE RECEIVED BY HEALTH DEPT.

JUN 16 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Walter Dabrowski 1005 Dundalk Avenue

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-200

67 5803

BALTIMORE CITY HEALTH DEPARTMENT

67 5803

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM H. COOKE

2. DATE AND HOUR PRONOUNCED DEAD

6-14-67

1:00 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1446 Marshall Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Oct. 1, 1910

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Exterminator

10B. KIND OF BUSINESS OR INDUSTRY

Sanitation

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Unknown Cooke

14. MOTHER'S MAIDEN NAME

Sarah A. Fagan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. Eliz. Cooke

ADDRESS

1446 Marshall St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

R. S. Fisher

M.D.

ASSISTANT MEDICAL EXAMINER ☐

6-14-67

EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6 17 67

23C. NAME OF CEMETERY or CREMATORY

Holy Cross

23D. LOCATION

(City, town, or county)

Brooklyn, A. A. Co. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 16 1967

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Mc Gully

ADDRESS

130 E. Fort Ave

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 11/11/01 BY 60322
UCBAW

FINNEY

6 1267

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT												Registered No. 67 5804	
67 5804 CERTIFICATE OF DEATH													
BIRTH NO.													
M.E. CASE NO.													
1. NAME OF DECEASED (Type or Print) <u>Taylor, Phillip R.</u>						2. DATE AND HOUR OF DEATH <u>12 JUNE 67 11:40 A.M.</u>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>The Johns Hopkins Hospital</u>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>VA.</u> B. COUNTY <u>V-43</u>							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Dahlgren</u>							
						D. STREET ADDRESS (If rural, give location) <u>727 Sampson Rd.</u>							
5. SEX <u>male</u>		6. RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>		8. DATE OF BIRTH <u>11-28-37</u>		9. AGE (In years last birthday) <u>29</u>		If Under 1 Yr. Months: Days: Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Federal Gov.</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Federal Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Colonial Beach, VA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>Westmoreland</u>			
13. FATHER'S NAME <u>Ernest Cecil Taylor</u>						14. MOTHER'S MAIDEN NAME <u>Virginia Wynne Nuckols</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <u>yes</u> <u>Air Force 1955-1959</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT (middle) <u>Mary Taylor Davis</u>				ADDRESS <u>8400 South West - 148 Drive</u>			
18. <u>193.0</u> CAUSE OF DEATH						INTERVAL BETWEEN ONSET AND DEATH <u>midnight</u>							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CEREBRAL EDEMA</u>						(A) DUE TO							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>GLIOBLASTOMA MULTIFORME</u>						(B) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						(C) DUE TO							
19A. DATE OF OPERATION <u>10/8/64</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BRAIN TUMOR</u>				20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>11 June</u> 19 <u>67</u> to <u>12 June</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12 June</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE <u>Merwyn Bagan</u>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>12 June 67</u>			
23C. PHYSICIAN'S NAME (Type) <u>MERWYN BAGAN</u>						23D. ADDRESS M.D. <u>JOHNS HOPKINS HOSPITAL</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/15/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Paul's Cemetery</u>				24D. LOCATION (City, town, or county) (State) <u>Owens, Virginia</u>					
25A. DATE RECEIVED <u>JUN 16 1967</u>		25B. NAME OF REGISTRAR <u>Phyllis E. Taylor</u>				25C. FUNERAL DIRECTOR <u>Nash & Slaw</u>				ADDRESS <u>Box 366 Ninde, Virginia 22526</u>			

Wickham Basin

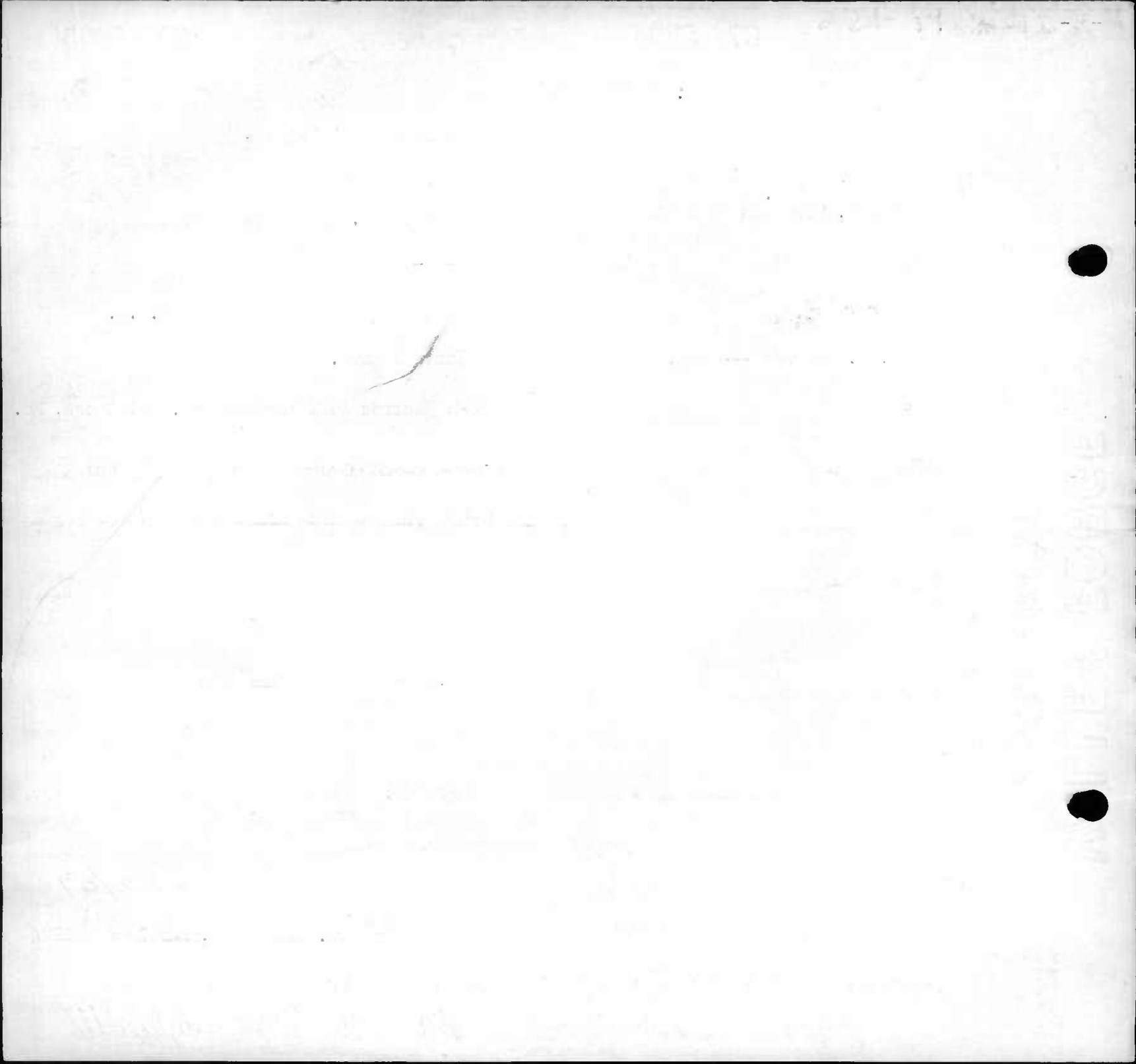
Johns Fork West Fork

No

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. H-156		67 5805		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5805	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) THOMAS W. HEAVNER				2. DATE AND HOUR OF DEATH 6/12 67 7 45 A			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224				A. STATE Maryland B. COUNTY Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) White Marsh			
				D. STREET ADDRESS (If rural, give location) Keithly Rd. 21162 005			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-29-04	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME W. W. Heavner --- Dec.				14. MOTHER'S MAIDEN NAME Laura ? Dec.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT BOH: Records 4940 Eastern Ave. Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) BRONCHOGENIC CA.				CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 8 MOS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO PNEUMONIA		1 WEEK	
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/29 19 67 to 6/12 19 67 , that (I) (we) last saw the deceased alive on 6/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ian Sherk				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/12/67	
23C. PHYSICIAN'S NAME (Type) IAN SHENK				23D. ADDRESS 550 N. BROADWAY 4940 Eastern Ave. Baltimore, Maryland #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-16-67		24C. NAME OF CEMETERY or CREMATORY Queenpoint Cemetery		24D. LOCATION (City, town, or county) (State) Keyser, W. Va.	
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1967		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Harry W. Haight		ADDRESS Sylva, Va.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5806	
BIRTH NO. 67 5806		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Keys Griffin		2. DATE AND HOUR OF DEATH June 14, 1967 3:30 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Division Street Baltimore, Maryland 21217		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-01 D. STREET ADDRESS (If rural, give location) 1825 W. North Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH ?-?-90	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Henry Keys		14. MOTHER'S MAIDEN NAME Patsia	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 219-03-4034		17. INFORMANT Selma Carter-stepdaughter ADDRESS same	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular Accident		CAUSE OF DEATH (A) DUE TO Arteriosclerotic Cardiovascular Disease (B) DUE TO Disease (C)		INTERVAL BETWEEN ONSET AND DEATH 5 days months years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cirrhosis of Liver		Unknown	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 9, 1967 to June 14, 1967 , that (I) (we) last saw the deceased alive on June 14, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elijah Saunders		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 14, 1967	
23C. PHYSICIAN'S NAME (Type) Elijah Saunders		23D. ADDRESS M.D. 1514 Division Street-Baltimore, Maryland 21217			
24A. BURIAL CREMATION, REMOVAL (Specify) June 19/67		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY Balto National	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. JUN 16 1967			
25B. NAME OF REGISTRAR W. A. R. F. R. R. R.		25C. FUNERAL DIRECTOR Brooks Ruggold		ADDRESS 1423 N. Carroll	

Henry King

Patience

Carthage, Kentucky
August 1st 1861
Dear Sir

Friends of Sir

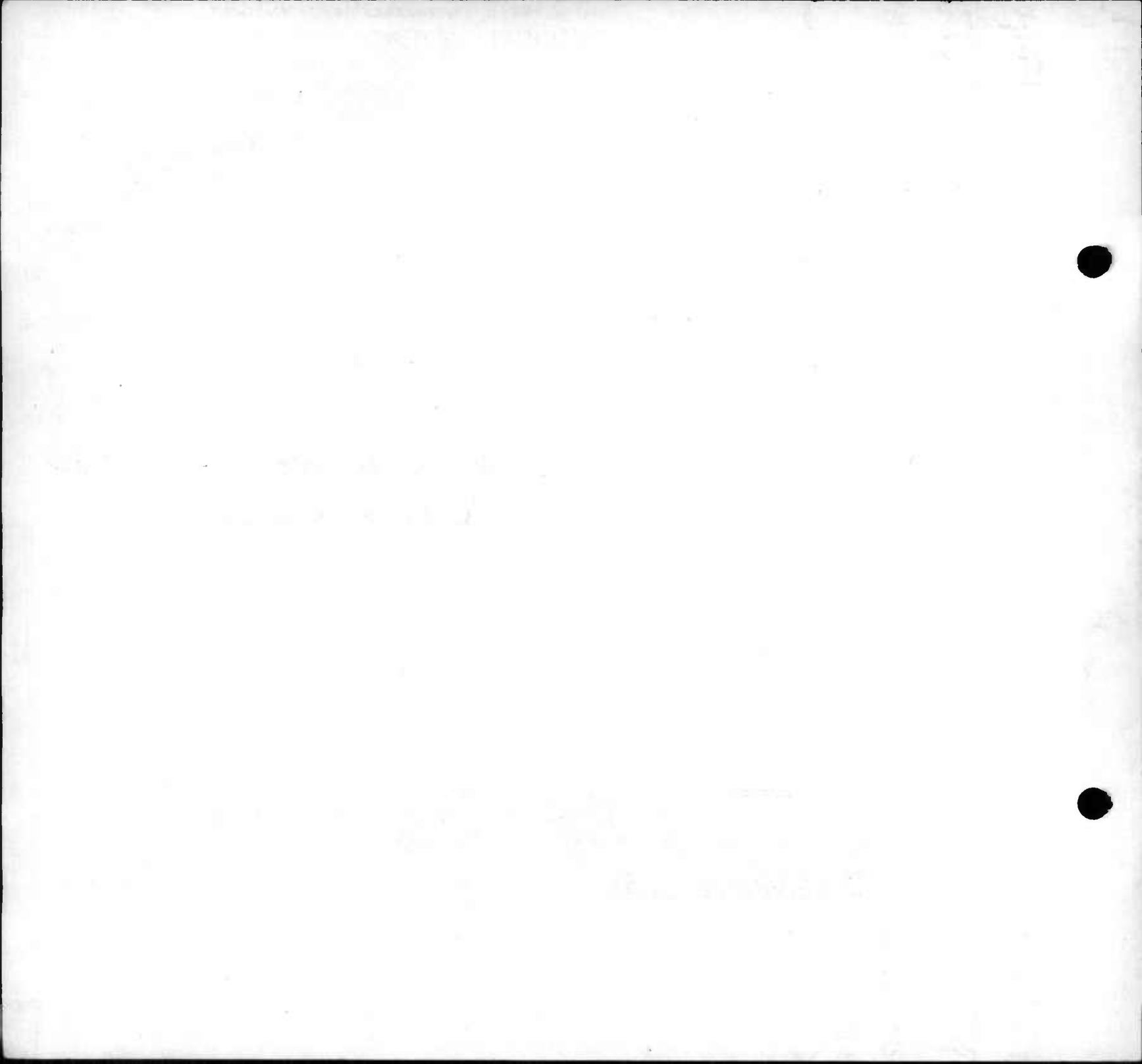
Right Honorable

James M. Smith
Secretary of the Board of Trustees
of the University of Kentucky

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5807	
BIRTH NO. 67 5807		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH June 15, 1967 M.			
1. NAME OF DECEASED (Type or Print) Edward E. Stickell		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore Co.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Catonsville D. STREET ADDRESS (If rural, give location) 572 Edmonson Avenue			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4/17/07	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Source Security Analysis		10B. KIND OF BUSINESS OR INDUSTRY U. S. Government		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Samuel F. Stickell		14. MOTHER'S MAIDEN NAME Minnie Ellers	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Edward Stickell ADDRESS 572 Edmonson Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH (A) myocardial infarction DUE TO (B) arteriosclerotic heart disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 1957 to June 12, 67 19 June 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph D'Antonio		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/16/67	
23C. PHYSICIAN'S NAME (Type) Joseph D'Antonio		23D. ADDRESS 100 North Broadway			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/17/67		24C. NAME OF CEMETERY or CREMATORY Lakeview	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1967		25B. NAME OF REGISTRAR Witzke's		25C. FUNERAL DIRECTOR ADDRESS 4101 Edmonson Avenue	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5808		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5808	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) M. Bernardine Droski			June 14, 1967 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 405 Random Road Balto., Md. - 21229			A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-31 D. STREET ADDRESS (If rural, give location) 405 Random Road		
5. SEX F	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Mar. 24, 1906	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Hutzler Bros.	11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James E. McDonnell			14. MOTHER'S MAIDEN NAME Nannie Healy		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-32-0799	17. INFORMANT Mrs. Richard Balmert		ADDRESS 6326 Frederick Rd. - 21228
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion - myocardial infarction			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 minutes
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO		(B) DUE TO
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) DUE TO		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 3</u> 19 <u>63</u> to <u>June 14</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 13</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE John F. Schaefer			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 15 1967
23C. PHYSICIAN'S NAME (Type) John Schaefer			23D. ADDRESS 401 Random Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/17/67	24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1967		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR Witzke F. D. ADDRESS 4101 Edmondson Ave.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5809		BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH		Registered No. 67 5809	
M.E. CASE NO. 5-216		1. NAME OF DECEASED (Type or Print) McFarland, Mrs. Nellie I.		2. DATE AND HOUR OF DEATH 6-15-67 4:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital 34		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5114 Edmondson Ave.			
5. SEX F	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 4-18-93	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Karcher, Jacob		14. MOTHER'S MAIDEN NAME Schmidt - KATHERINE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Hugh Ellison, 6108 Deerbrook Rd. Admission Street	
18. 45-1X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Anterior abdominal aorta		CAUSE OF DEATH (A) Anterior abdominal aorta (B) Terminal uremia (C)		INTERVAL BETWEEN ONSET AND DEATH 3 months 2 days	
19A. DATE OF OPERATION 6-12-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Anterior aorta		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 6-10-67 19 67 to 6-15 19 67 , that (we) last saw the deceased alive on 6-15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Milagros L. Guerrero		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/15/67	
23C. PHYSICIAN'S NAME (Type) MILAGROS L. GUERRERO		23D. ADDRESS BON SECOURS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/19/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 18 1967			
25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.			

111 Second Street

F. W. Wilson

Housewife
Teacher, Jacob

111 Second Street

11-18-93

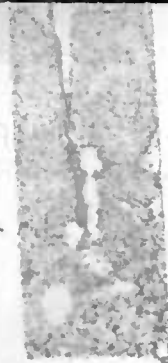
Thompson
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Main Street

111 Second Street
F. W. Wilson
Housewife
Teacher, Jacob

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 5810	
CERTIFICATE OF DEATH				Registered No. 67 5810	
BIRTH NO. FLU 55		M.E. CASE NO.		H.	
1. NAME OF DECEASED (Type or Print) FLEMING-WILLIS		2. DATE AND HOUR OF DEATH 6-14-67 2-35 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland		A. STATE Maryland B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 5162 Balto. Nat'l Pike			
5. SEX Male	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M.	8. DATE OF BIRTH 10-13-97	9. AGE (In years last birthday) 69 yrs	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Franklin Fleming		14. MOTHER'S MAIDEN NAME Eleanor ----		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Wm. H. Fleming 5162 Baltimore National Pike	
18. 463X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Pulmonary Embolization			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Thrombophlebitis - Right Leg			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Ascud & Decompensation and Pulmonary Edema			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-8-67 to 6-14-1967 , that (I) (we) last saw the deceased alive on 6-14-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anil M. Joshi		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ANIL M. JOSHI		M.D. 23D. ADDRESS Lutheran Hospital of Maryland 730 Ashburton St. Baltimore 21206			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/17/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D. BY HEALTH DEPT. JUN 18 1967		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Witzke F. D.		25D. ADDRESS 4101 Edmondson Ave.			



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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5811 4	
BIRTH NO. 67-11292 67 5811		CERTIFICATE OF DEATH		67 5811 4	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BRUCE BABY GIRL		JUNE 13 1967 1:25P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
40 ST AGNES HOSPITAL			MD		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE		
			D. STREET ADDRESS (If rural, give location)		
			1601 POPLAND STREET		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE	NEVER MARRIED	6-13-67		12 42
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				BALTIMORE, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
HOLLIS			GWENDOLYN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				ST AGNES HOSPITAL CATON & WILKENS AVE. BALTIMORE MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
776 X I			PREMATURITY		
ANTECEDENT CAUSES			(A) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 13 1967 to JUNE 13 1967, that (I) (we) last saw the deceased alive on JUNE 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
REYNALDO O. GUZMAN M.D.				6-13-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
REYNALDO O. GUZMAN		CATON AND WILKENS AVE. BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		6/16/67		Baltimore National	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 16 1967		Robert E. Feltner		Witzke, F. D. - 4101 Edmondson Ave.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5812		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5812	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>HARRIS, John</i>		
2. DATE AND HOUR OF DEATH <i>6/13/67 9⁰⁵ AM</i>			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
THE JOHNS HOPKINS HOSPITAL <i>33</i>			A. STATE <i>MARYLAND</i>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE		
			D. STREET ADDRESS (If rural, give location)		
			1744 ASHLAND AVENUE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
MALE	NEGRO	MARRIED	6-13-23	44	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Laborer			Baltimore		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOHN HARRIS			ESTHER HILL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			17. INFORMANT		
			Hopkins Hospital Record		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease or complication which caused death)			CAUSE OF DEATH		
Chronic Alcoholism			20 yrs		
Chronic Cirrhosis			20 yrs		
Esophageal bleeding			2 mos.		
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/27/67</i> 19 to <i>6/13</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6/13/67</i> 19, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Clarence H. Brown III</i>				23B. DATE SIGNED <i>6/13/67</i>	
23C. PHYSICIAN'S NAME (Type) CLARENCE H. BROWN III				23D. ADDRESS JOHN HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		6-17-67		Mt. Calvary Cem & Co	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 16 1967		Robert E. Johnson		Boyer Sanders 217 E. Preston St	

[Faint handwritten notes, possibly bleed-through from the reverse side.]

10/24/2010 10/24/2010

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5813		CITY HEALTH DEPARTMENT		Registered No. 67 5813	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) MR. MELVIN J. DEMBECK			6-12-67 3 15 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Ben Secours Hospital 235 W. FAYETTE ST. BALT. MD. 21203			A. STATE MARYLAND B. COUNTY Howard Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) MARIOTTOVILLE 63-00 D. STREET ADDRESS (If rural, give location) Box 94A - DRIVER RD.		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-28-1907	9. AGE (In years lost birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME MR. ANTHONY DEMBECK			14. MOTHER'S MAIDEN NAME MARIA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS SAME AS ABOVE MRS. ANNA DEMBECK - WIFE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 492X I CAUSE OF DEATH Kneumonia			INTERVAL BETWEEN ONSET AND DEATH 14 DAYS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral Vascular Acc.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from May 29/ 1967 to June 12/ 1967 that (I) (we) last saw the deceased alive on June 12/ 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A.M. Ghiladi M.D.			23B. DATE SIGNED June 12/67		
23C. PHYSICIAN'S NAME (Type) Abdolhamid Ghiladi M.D.			23D. ADDRESS Ben Secours Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/16/67	24C. NAME OF CEMETERY or CREMATORY St. Stanislaus	24D. LOCATION (City, town, or county) (State) Baltimore + Dundalk City		
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1967	25B. NAME OF REGISTRAR Robert E. Fisher	25C. FUNERAL DIRECTOR Thos. E. Fisher 1930 Eastern Ave.			

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J. H. Thompson
J. H. Thompson
J. H. Thompson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5814		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5814	
<div style="display: flex; justify-content: space-between;"> <div> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) ROOSEVELT RICHBURG</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 6/4/67 9:30 P.M.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 31</p> <p>D. STREET ADDRESS (If rural, give location) 215 N. WASHINGTON ST.</p>		
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 11-9-1901	9. AGE (In years lost birthday) 65	<p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer</p>			<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) Manning S.C.</p>
<p>13. FATHER'S NAME EUGENE RICHBURG</p>			<p>14. MOTHER'S MAIDEN NAME GEORGIA TELDER</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO.</p>	<p>17. INFORMANT ADDRESS Neale Wells 91877 Chester St</p>		
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH Pneumonia</p> <p>INTERVAL BETWEEN ONSET AND DEATH</p>			<p>19. ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.</p> <p>Intracerebral Hemorrhage</p>		
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) NO</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 5/22 1967 to 6/4 1967, that (I) (we) lost saw the deceased alive on 6/4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="radio"/> (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE R. Rampton M.D.</p>				<p>23B. DATE SIGNED 6/4/67</p>	
<p>23C. PHYSICIAN'S NAME (Type) DR. R. RAMPTON</p>				<p>23D. ADDRESS THE JOHNS HOPKINS HOSPITAL M.D.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE Jan 9/67</p>		<p>24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery</p>	
<p>24D. LOCATION (City, town, or county) A.A. County Md</p>		<p>24E. (State)</p>			
<p>25A. DATE REC'D BY HEALTH DEPT. JUN 16 1967</p>		<p>25B. NAME OF REGISTRAR W. B. Elicker</p>		<p>25C. FUNERAL DIRECTOR ADDRESS 1129 N. Calhoun</p>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

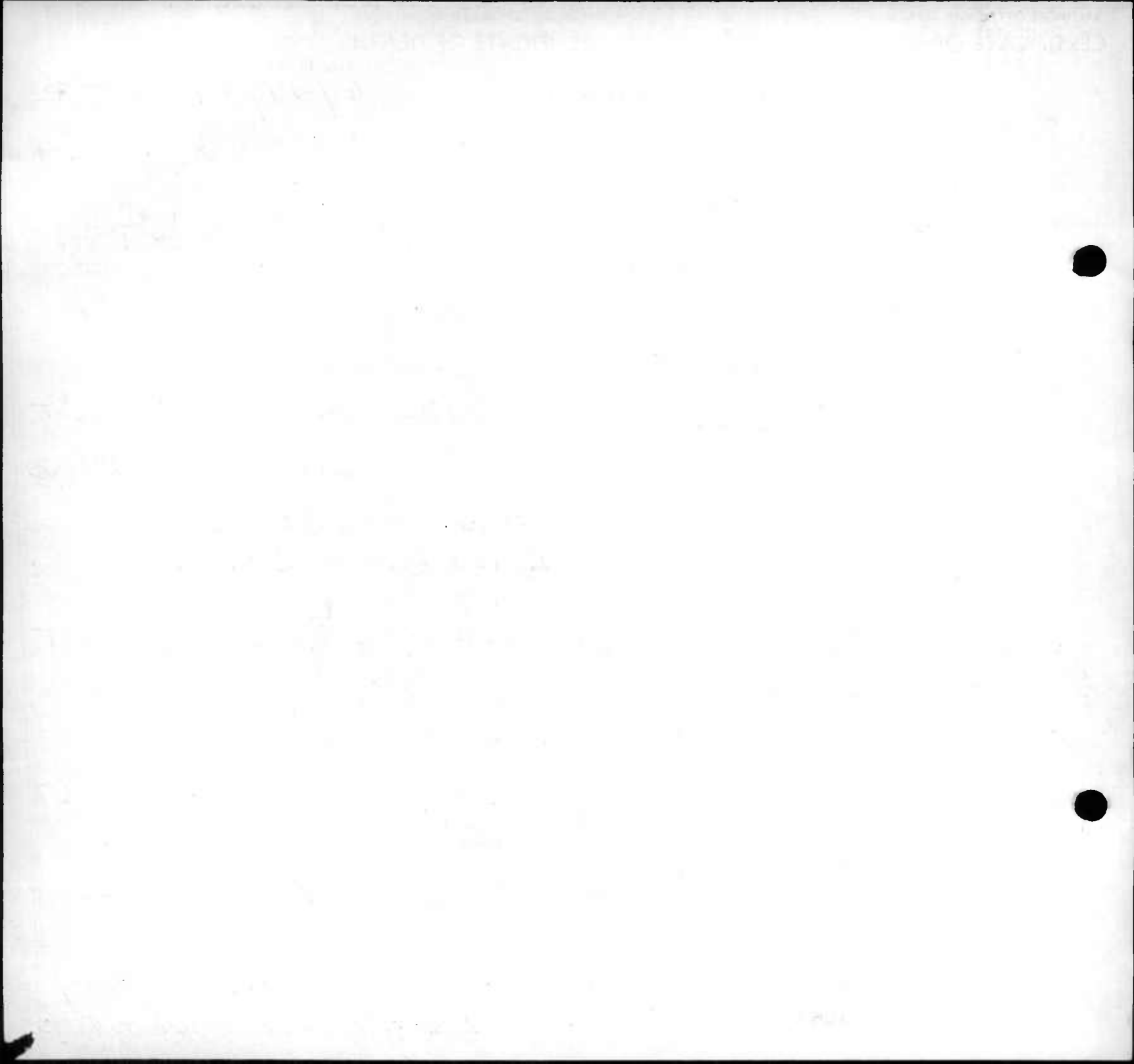
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5815	
BIRTH NO. 67 5815		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Mr. Henry Gillian</i>		2. DATE AND HOUR OF DEATH <i>6/13/67 3:05A. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>9-07</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>1543 East 29th Street</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>07/16/16</i>	9. AGE (In years last birthday) <i>50</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Plummer Gillian</i>		14. MOTHER'S MAIDEN NAME <i>Mary Bartte</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Mary Gillian</i> ADDRESS <i>same</i>	
18. <i>331X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cerebro Vascular Occident 14d</i> DUE TO (B) <i>Bronchopneumonia 13d</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from <i>5/29</i> 19 <i>67</i> to <i>6/13</i> 19 <i>67</i> . that (I) (we) last saw the deceased alive on <i>6/12</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nat Erskine Watson Jr</i>				23B. DATE SIGNED <i>6/13/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>NAT ERSKINE WATSON, JR.</i>				23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>June 17/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cmn</i>	
24D. LOCATION (City, town, or county) (State) <i>A.A. County</i>		25A. DATE OF DEATH <i>JUN 15 1967</i>		25B. NAME OF REGISTRAR <i>John E. Feltner</i>	
25C. FUNERAL DIRECTOR <i>John E. Feltner</i>		25D. ADDRESS <i>1129 N. Carroll St</i>			

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side. Some words like "Memorial", "Museum", and "Galleries" are partially visible.]

FUNERAL DIRECTOR: IMPORTANT

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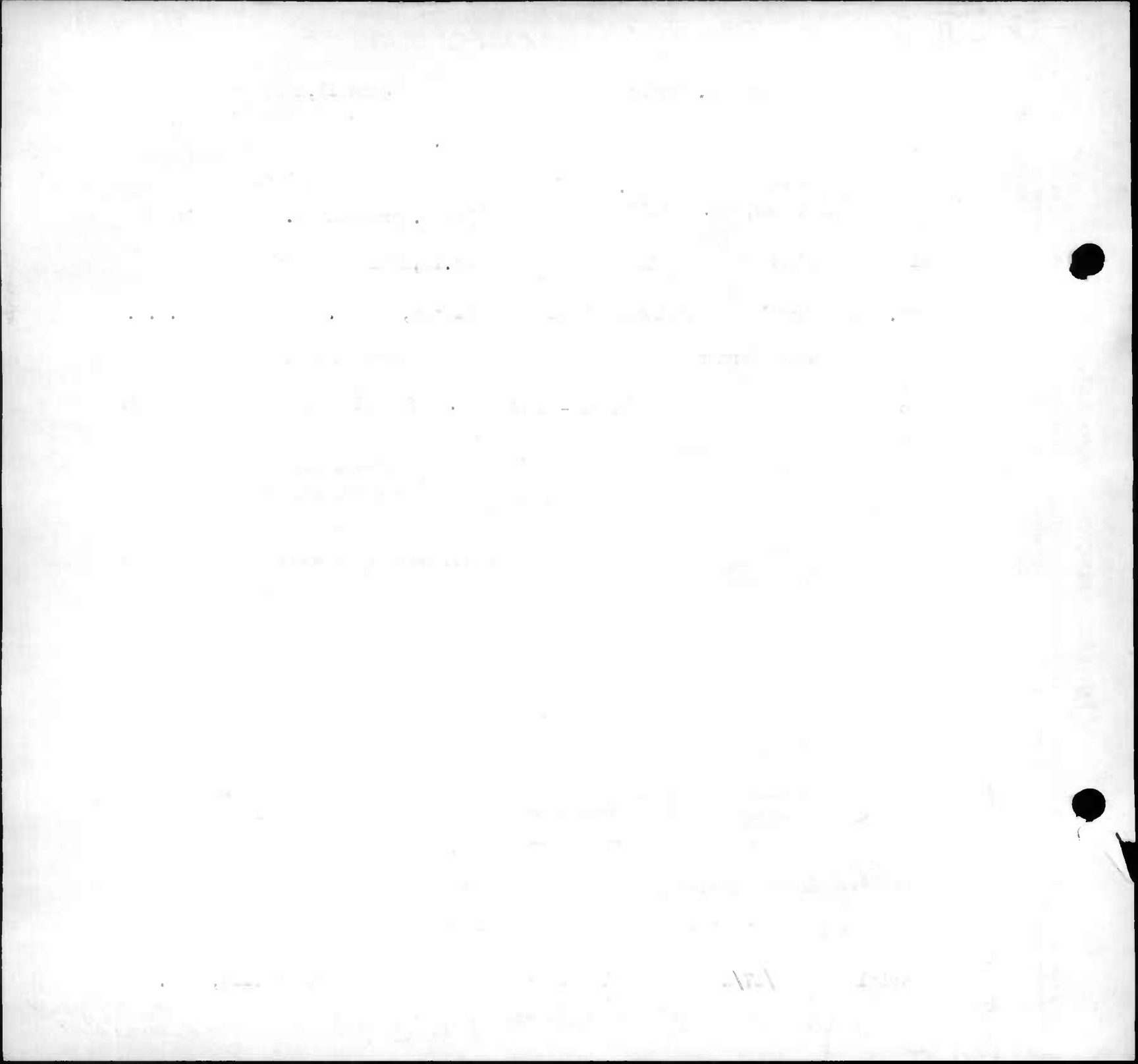
BIRTH NO. 67 5816		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5816	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PRATO MARTHA		2. DATE AND HOUR OF DEATH 6/14/67 7:33 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. AGE (In years last birthday) 79	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI		A. STATE Md. B. COUNTY BALTIMORE CITY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 28-41	
D. STREET ADDRESS (If rural, give location) 4207 BELVIEW Ave.		6. DATE OF BIRTH 11/10/87		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	
5. SEX FEMALE		6. RACE CAUC.		8. DATE OF BIRTH 11/10/87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT Home		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 79	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Vincent Nadio	
14. MOTHER'S MAIDEN NAME UNKNOWN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Freitag Funeral Home - 157 W. Commerce St		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.)	
CAUSE OF DEATH (A) MESENTERIC INFARCTION (B) ARRHYTHMIC FIBRILLATION (C) ARTERIOSCLEROTIC C.V.D.		INTERVAL BETWEEN ONSET AND DEATH ~ 24 hrs		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS - AdenoCa of R BREAST	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED (While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>)		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/12 1967 to 6/14 1967, that (I) (we) last saw the deceased alive on 6/14 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James Sobel		23B. DATE SIGNED 6/14/67		23C. PHYSICIAN'S NAME (Type)	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-17-1967		24C. NAME of CEMETERY or CREMATORY ST MARY'S Cemetery	
24D. LOCATION (City, town, or county) (State) BRIDGETON, New Jersey		25A. DATE REC'D BY HEALTH DEPT. JUN 16 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Ellsworth Armacost - 4600 Liberty Hgts		25D. ADDRESS		25E. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

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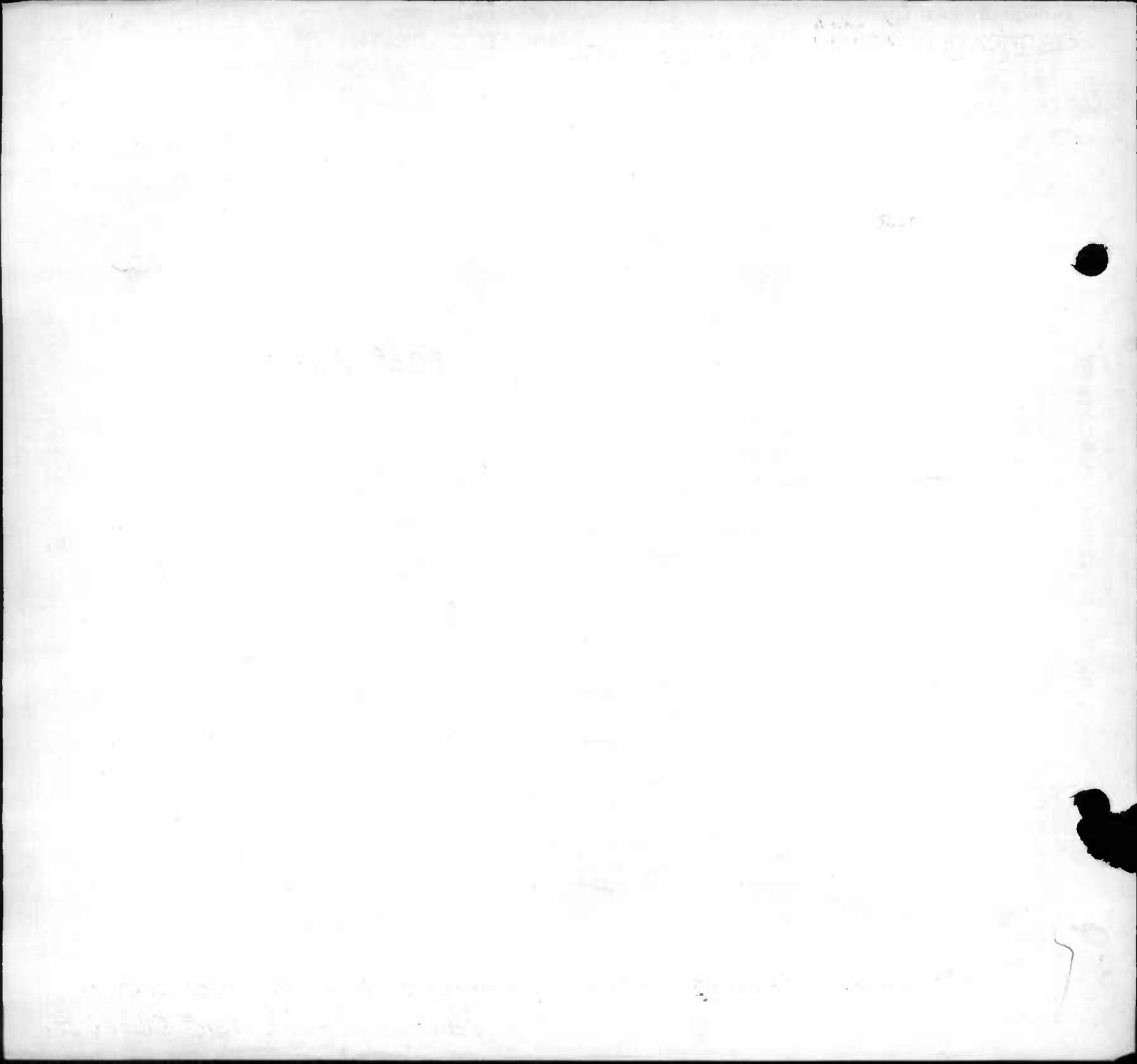
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5817	
BIRTH NO. 67 5817		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Harry E. Warner		June 13, 1967 12.20 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
00 358 South Cornwall St. Baltimore, Md. 21224			Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26 05		
			D. STREET ADDRESS (If rural, give location) 358 S. Cornwall St. 24		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	White	Widowed	Dec. 18, 1891	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Supt. (Retired)		Bethlehem Steel		Alesia, Md.	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Noah Warner			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			216-10-5149A		Mrs. Gajewski 4347 Sheldon Avenue
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.14177X			(A) Coronary Occlusion		3 hours
ANTECEDENT CAUSES			(B) Arteriosclerotic Cardio-Vascular Disease		Unknown
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) Carcinoma of Prostate		Unknown
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 19 1966 to 6/13 1967, that (I) (we) last saw the deceased alive on June 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Philibert Artigiani M.D.				June 14/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Philibert Artigiani M.D.				2305 Mayfield Ave Balto Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6/17/1967		Druid Ridge	
				24D. LOCATION (City, town, or county) (State)	
				Pikesville, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 16 1967		Robert E. Fabela		3001/27th Ave Balto Md.	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5818	
BIRTH NO. 67 5818				CERTIFICATE OF DEATH	
M.E. CASE NO. William Elwood Batts Jr.				1. NAME OF DECEASED (Type or Print) Batts, Baby Boy	
2. DATE AND HOUR OF DEATH 6-11-67 1 8 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital 33				A. STATE MD. B. COUNTY BALTIMORE 8-07	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 1532 EAST BIRD BALTIMORE				D. STREET ADDRESS (If rural, give location) 1532 EAST BIDDLE ST.	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never	8. DATE OF BIRTH 5/20/67	9. AGE (In years, lost birthday) 22	10. Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA - Maryland
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME William Batts		
14. MOTHER'S MAIDEN NAME Kate Rawles			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS old chart		
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Multiple Congenital Malformations 22	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) Possible Mosaic D Trisomy 22	
ANTECEDENT CAUSES				(C) Also Pneumonitis ?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (if this hospital) attended the deceased from 19 67 to June 10 19 67, that (I) (we) last saw the deceased alive on June 8 19 67 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			
23A. SIGNATURE Barbara C Wagner M.D.				23B. DATE SIGNED 6/11/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS SINAI HOSPITAL OF BALT.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-13-67		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) Anne Arundel Co. Md.		25A. DATE REC'D JUN 16 1967			
25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR ADDRESS Randolph J. Collick 2431 E. Oliver St.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MILDRED HINTON

2. DATE AND HOUR PRONOUNCED DEAD

6-14-67

5:45 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1523 Bond Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

10-13-1918

9. AGE (In years, lost birthday) If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

49

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Hypertensive cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m. WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-14-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-17-67

23C. NAME of CEMETERY or CREMATORY

Mount Calvary Cemetery

23D. LOCATION

(City, town, or county)

A. A. County

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 16 1967

Collick Funeral Home 2431 E. Oliver St.

10-13-1918

Personal

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5820	
BIRTH NO. 67 5820		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ROBERT CARTER			
2. DATE AND HOUR OF DEATH		JUNE 12, 1967 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
102 S. FAULEY ST		MD. BALTO			
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
8. DATE OF BIRTH OCT 17, 1911		9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
BETH. STEEL		11. BIRTHPLACE (State or foreign country) UTAH		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DANIEL CARTER		14. MOTHER'S MAIDEN NAME ELLEN SHUTTLEWORTH		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN	
16. SOCIAL SECURITY NO. 213-03-6067		17. INFORMANT ELSIE CARTER		ADDRESS ABOVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Cancer of the mouth - metastasizing in the neck - chest			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from July 8, 1966 to June 12, 1967, that (I) (we) last saw the deceased alive on June 12, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marcos Revin		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-14-67	
23C. PHYSICIAN'S NAME (Type) MARCOS REVIN		23D. ADDRESS 201 WISE AVE BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/15/67		24C. NAME of CEMETERY or CREMATORY GARDENS OF FAITH BALTO. MD	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR J. E. J. J. J.	
25C. FUNERAL DIRECTOR J. E. J. J. J.		ADDRESS 300 MACE			

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67 5821

BALTIMORE CITY HEALTH DEPARTMENT

67 5821

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

YVONNE PARTY

2. DATE AND HOUR PRONOUNCED DEAD

June 11, 1967 11:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

18 Beach Drive

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

NEVER MARRIED

8. DATE OF BIRTH

MAR. 2 1953

9. AGE (In years last birthday)

14

10. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

ILLINOIS

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN O. PARTY

14. MOTHER'S MAIDEN NAME

IRENE R. LEE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHN PARTY

ADDRESS

A BOVE

18.

E823.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrocranial injuries DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Orems Road and Entrance Road

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

6-10-67 2:00 A.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto-pole collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion

resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 12, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

6/15/67

23C. NAME OF CEMETERY or CREMATORY

KRIDERS CEM

23D. LOCATION

WESTMINISTER

(City, town, or county)

(State)

MD

24A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

J. G. CORNELLY SONS

ADDRESS

300 MACE

VALLEY PARK

WILLIAMSON COUNTY

MISSOURI

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 5822 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Reg. No. 67 5822	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) PRITCHARD Mrs. ALMA M.				6-15-67 1030 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL			A. STATE MARYLAND		
			B. COUNTY BALTIMORE		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 9-23		
			D. STREET ADDRESS (If rural, give location) 3701 Yolanda Rd		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9-28-1894	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY B&O RAILROAD		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME HENRY RIPPEL		
14. MOTHER'S MAIDEN NAME MARGARET EBERWEIN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 705-03-6020			17. INFORMANT ROBERT R. RIPPEL		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction			INTERVAL BETWEEN ONSET AND DEATH 5 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hemorrhage			? Adenocarcinoma, Bladder		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 9-14-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hematuria (Cystoscopy)		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 6-10-67 19 to 6-15 19 67 , that he (we) last saw the deceased alive on 6-15 19 67 and that in (my) my opinion death occurred on the date and hour and from the causes stated above. (I) the (did) did not view the body after death.					
23A. SIGNATURE William T. Mason				23B. DATE SIGNED 6/15/1967	
23C. PHYSICIAN'S NAME (Type) William T. Mason				23D. ADDRESS MERCY Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/19/1967		24C. NAME OF CEMETERY or CREMATORY Oaklawn	
24D. LOCATION (City, town, or county) (State) Balto. Co., Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967			
25B. NAME OF REGISTRAR Robert E. Baskin		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			

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Hawthorne -
Hawthorne -

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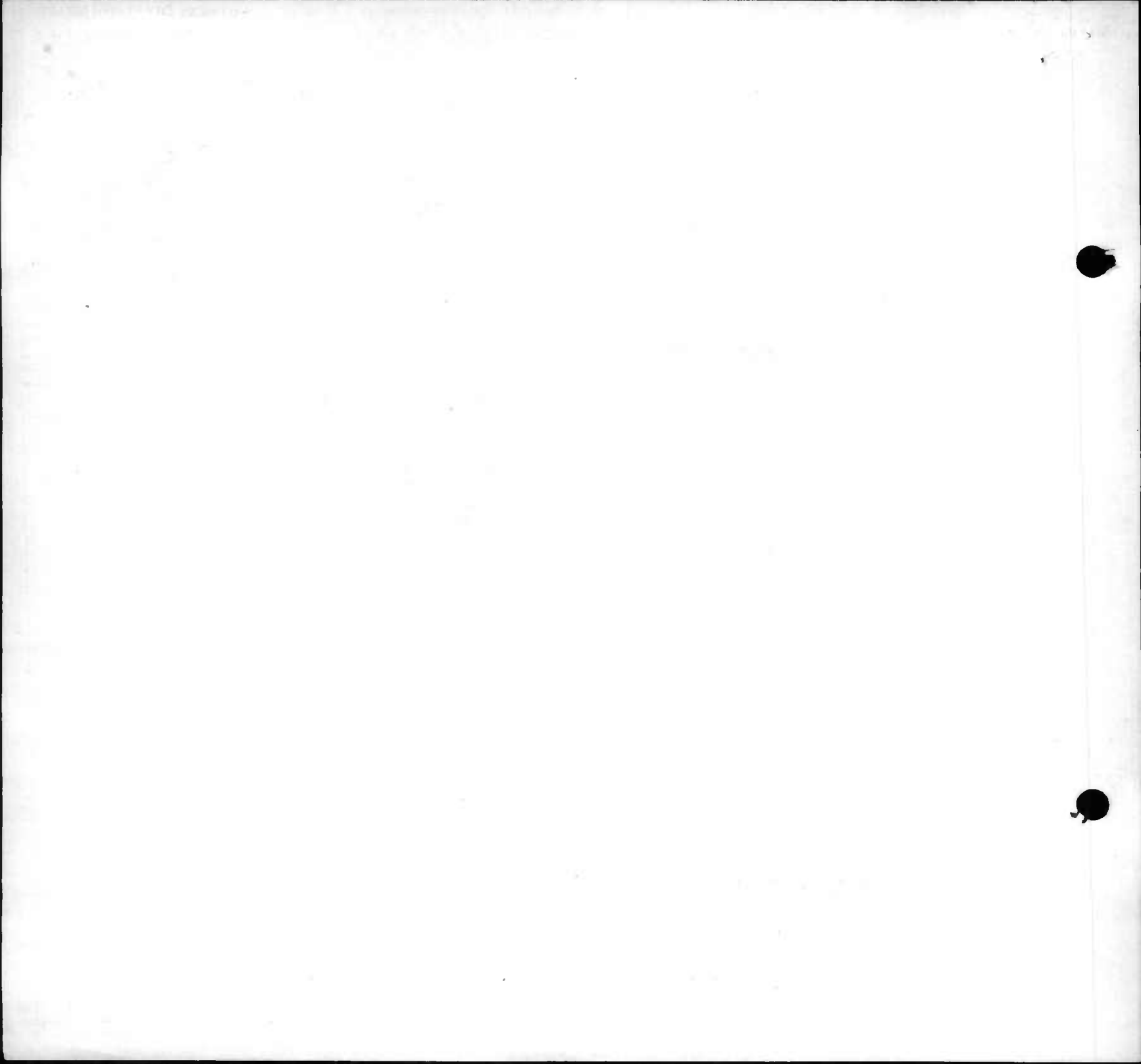
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

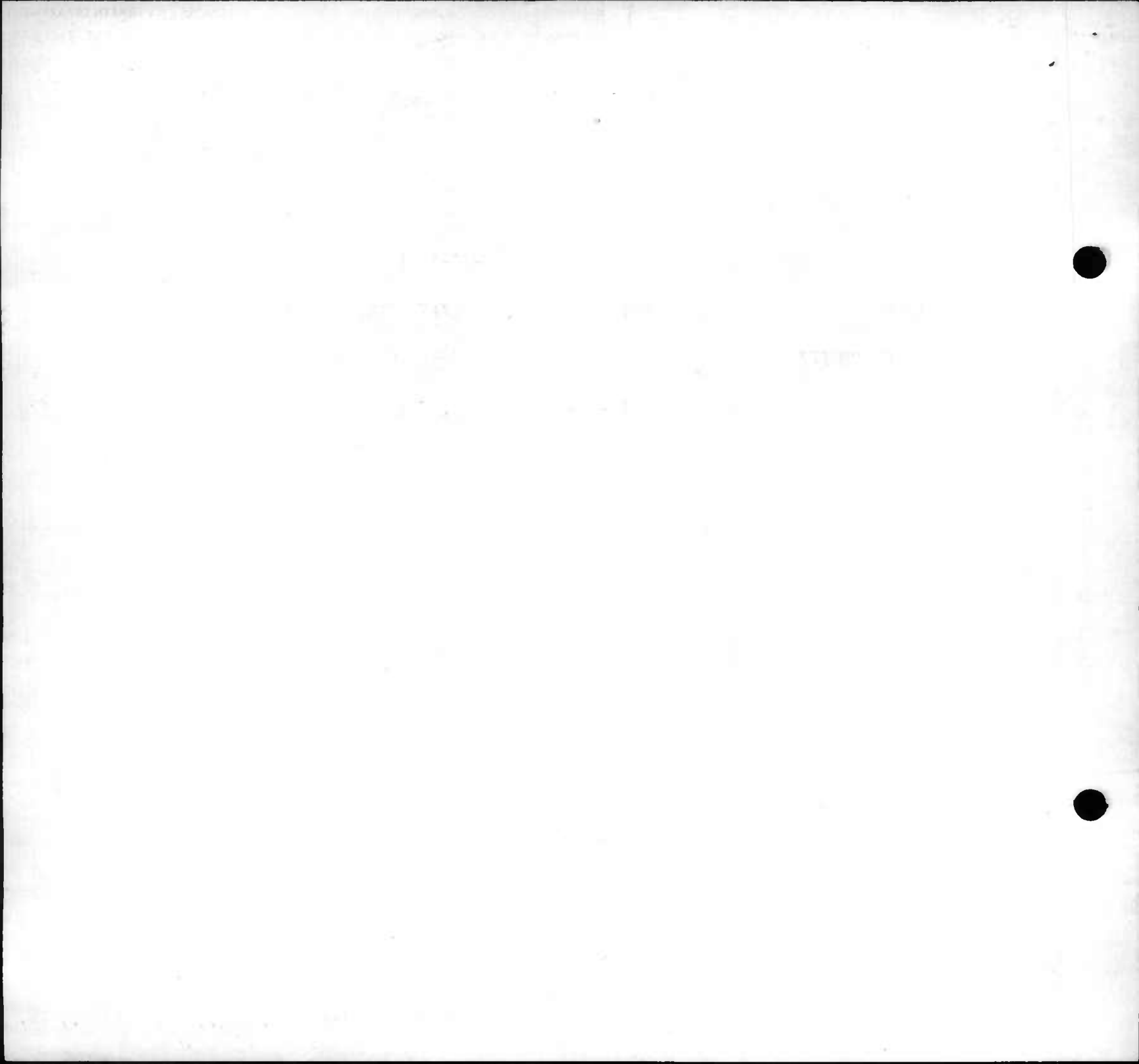
BALTIMORE CITY HEALTH DEPARTMENT									
67 5823 CERTIFICATE OF DEATH					Registered No. 67 5823				
BIRTH NO. 67 5823					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) DR. MOSES SAMUEL SHILING					2. DATE AND HOUR OF DEATH June 12, 1967 1 A. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 5711 Ridgedale Road					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-15 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5711 Ridgedale Road				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH NOV. 4, 1907	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician			10B. KIND OF BUSINESS OR INDUSTRY Medical		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Benjamin Shiling					14. MOTHER'S MAIDEN NAME Mary Shapiro				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no (unknown)) (If yes, give year or dates of service) Yes WW II P.H.S.			16. SOCIAL SECURITY NO. 217-14-6990		17. INFORMANT Mrs. Sophie Shiling				ADDRESS 5711 Ridgedale Road
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) DUE TO Acute Myocardial Infarction					INTERVAL BETWEEN ONSET AND DEATH Sudden				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DUE TO ASHD					10 yrs.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from April 1963 to June 12, 1967, that (I) (we) last saw the deceased alive on June 10, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Barnett Berman, M.D.					23B. DATE SIGNED June 12, 1967				
23C. PHYSICIAN'S NAME (Type) Dr. Barnett Berman					23D. ADDRESS 611 Park Avenue				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 13, 1967		24C. NAME of CEMETERY or CREMATORY Shaarei Zion Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR R. B. Berman		25C. FUNERAL DIRECTOR Soy Levinson & Bros.		ADDRESS 6010 Reisterstown Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

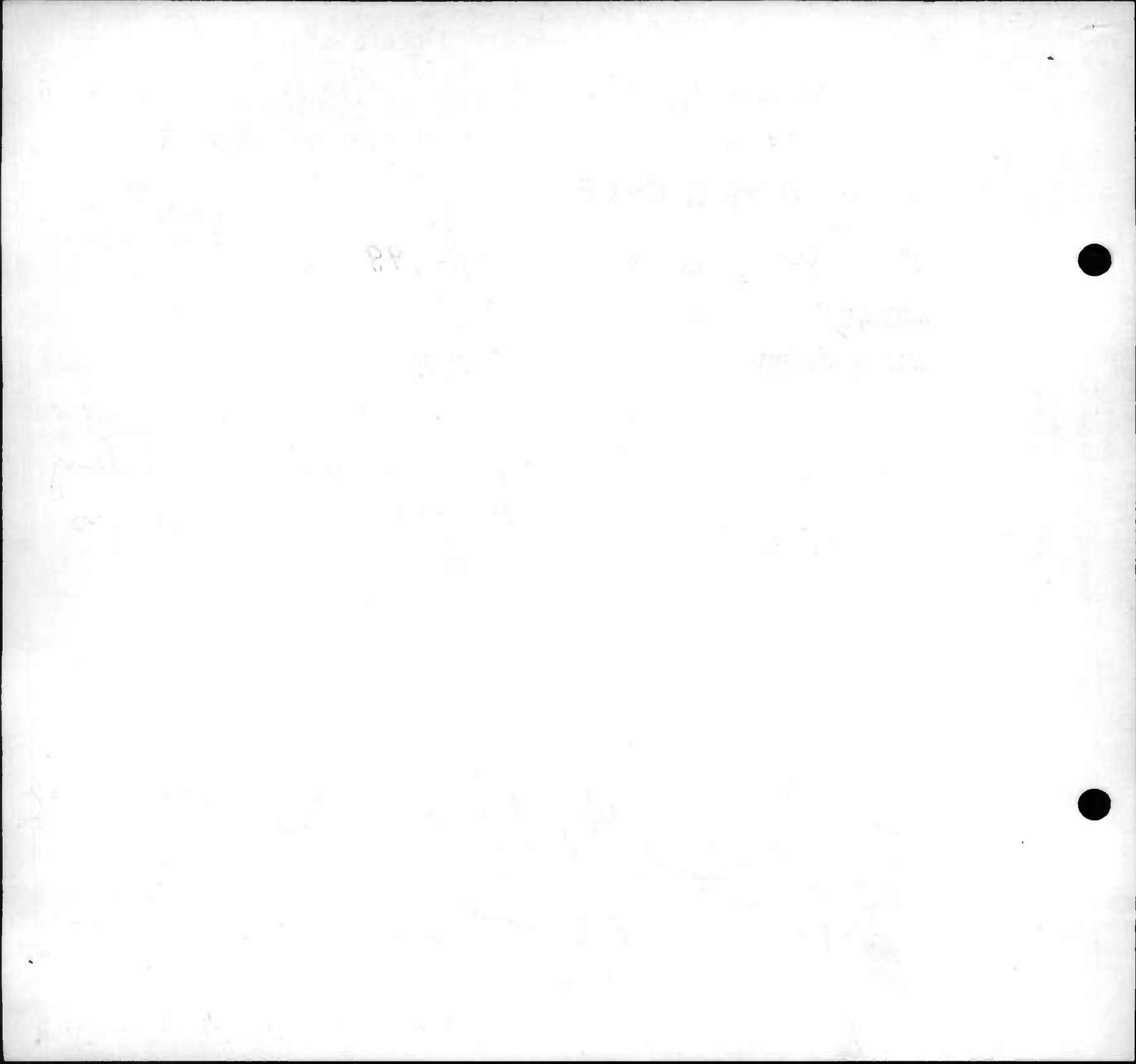
BALTIMORE CITY HEALTH DEPARTMENT														
67 5824					CERTIFICATE OF DEATH					Registered No. 67 5824				
BIRTH NO. 67 5824										M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) NATHAN HURWITZ					2. DATE AND HOUR OF DEATH JUNE 12, 1967 6:35 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE					5. AGE (In years last birthday) 65				
FULL NAME OF HOSPITAL OR INSTITUTION 3703 MARMON AVENUE					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					D. STREET ADDRESS (If rural, give location) 3703 MARMON AVENUE				
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 8-15-1901		9. AGE (In years last birthday) 65		10. Under 1 Yr. Months: Days		11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK					10B. KIND OF BUSINESS OR INDUSTRY CITY OF BALTO.					11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND				
12. CITIZEN OF WHAT COUNTRY? USA					13. FATHER'S NAME ISAAC HURWITZ					14. MOTHER'S MAIDEN NAME ANNIE CHESSLER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 217-01-7495					17. INFORMANT MRS. HELEN HURWITZ, 3703 MARMON AVENUE #7				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11					CAUSE OF DEATH (A) Recurrent Corronary Thrombosis (B) 1895 (C)					INTERVAL BETWEEN ONSET AND DEATH				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II														
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1939 to 6/12 19 67 , that (I) (we) last saw the deceased alive on 6/5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <i>Milton Kirsh</i>										23B. DATE SIGNED 6/13/67				
23C. PHYSICIAN'S NAME (Type) MILTON KIRSH					23D. ADDRESS 4000 W. NORTHERN AVENUE									
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 6/13/67					24C. NAME of CEMETERY or CREMATORY MOGAN ABRAHAM				
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND					25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967					25B. NAME OF REGISTRAR Robert E. Smith				
25C. FUNERAL DIRECTOR SOLO LEVINSON & BROS. INC., 6010 REIST., RD.														



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

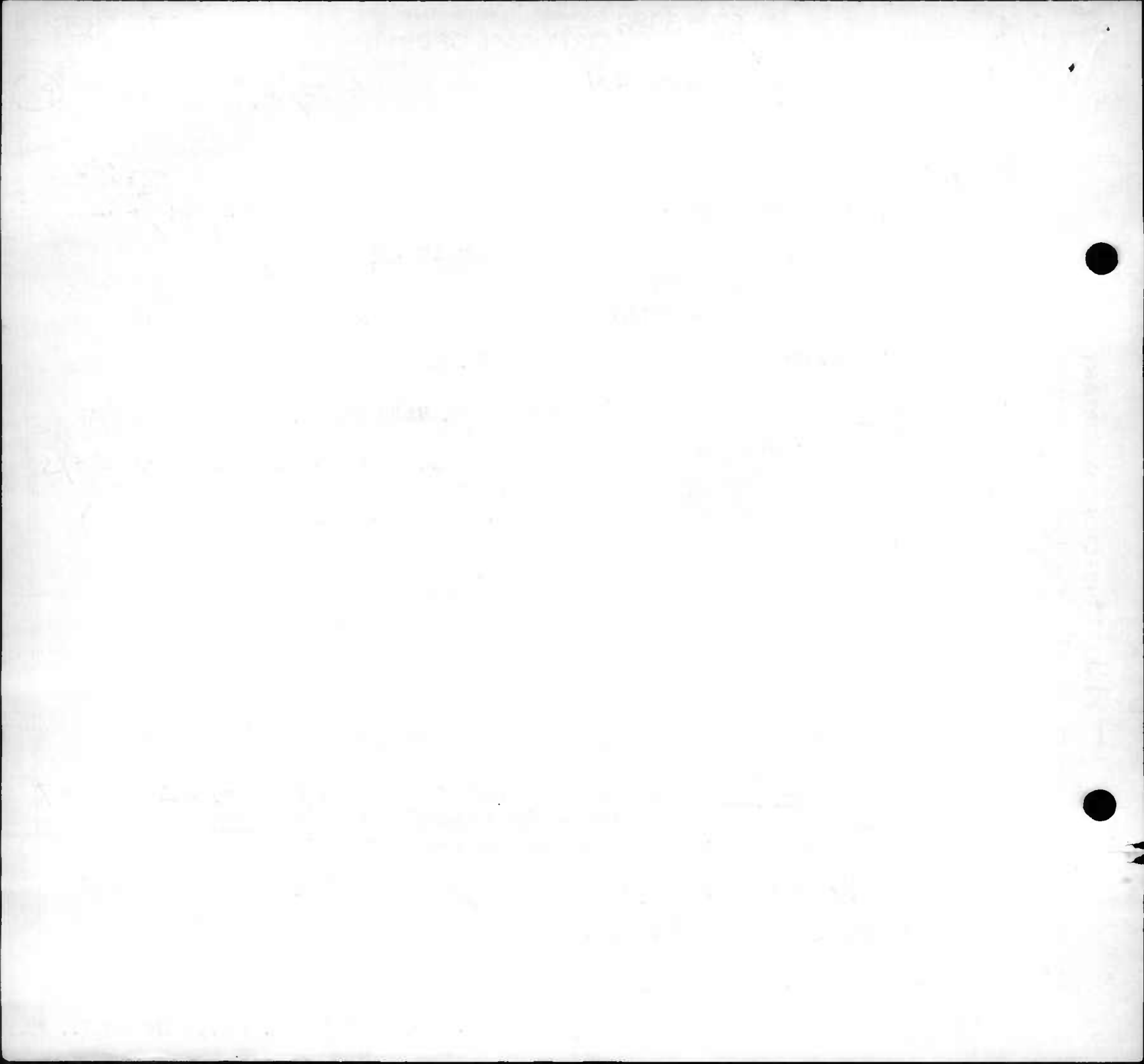
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5825</u>	
BIRTH NO. <u>67 5825</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Weisberg Tillie</u>			
2. DATE AND HOUR OF DEATH <u>6/12/67</u> <u>12:05 A.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u> Sinai Hosp of Balt. </u>		A. STATE <u>Maryland</u> B. COUNTY <u>Balt.</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>27-20</u>			
		D. STREET ADDRESS (If rural, give location) <u>3408 Pinkney ROAD</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WID</u>	8. DATE OF BIRTH <u>8/23/98</u>	9. AGE (In years lost birthday) <u>68</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>SOLOMON ROSENTHAL</u>			
14. MOTHER'S MAIDEN NAME <u>GUSSIE ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MRS. MURIEL SILVERSTEIN, 3408 PINKNEY ROAD</u>			
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <u>Myocardial Infarction</u>			
ANTECEDENT CAUSES		(B) DUE TO <u>ASHD</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>10 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/11</u> 19 <u>67</u> to <u>6/12</u> 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>6/12</u> 19 <u>67</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>David A. Spott</u>				23B. DATE SIGNED <u>6/12/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>D. A. SPOTT</u>				23D. ADDRESS <u>Sinai Hosp of Balt.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/13/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>CHIZUK AMUNO</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 19 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC., 6010 REIST., RD.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 5826		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5826	
BIRTH NO.		M.E. CASE NO. <u>MERVIS</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MARY CAPLAN</u>			2. DATE AND HOUR OF DEATH <u>6/12/67</u> <u>12.30</u> (P.M.)		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>3603 Labyrinth Rd, #15</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>6/12/1924</u>	9. AGE (In years last birthday) <u>42</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>		11. BIRTHPLACE (State or foreign country) <u>HENDERSON, KENTUCKY</u>	
13. FATHER'S NAME <u>SIMON SAMBURG</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>A 218-26-6637</u>		17. INFORMANT <u>MRS. NAOMI EGORIN, 6504 BAYTHORNE ROAD</u>
18. <u>330X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CEREBRAL VASCULAR ACCIDENT (SUBARACHNOID HEMORRHAGE)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>6/13/67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ANUSKE ENLARGED</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>SINAI HOSPITAL</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>SINAI HOSPITAL</u>			
21D. TIME OF INJURY (APPROX.) <u>6/12/67</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>STROKE</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>6/7</u> 19 <u>67</u> to <u>6/12</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/12</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. Hidalgo</u>				23B. DATE SIGNED <u>6/12/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>EDUARDO HIDALGO</u>				23D. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/13/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>ANUSKE ENLARGED</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 19 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>SOI LEVINSON & BROS. INC., 6010 REIST., RD.</u>			



1
G. 650

67 5827

BALTIMORE CITY HEALTH DEPARTMENT

67 5827

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH GREEN

2. DATE AND HOUR PRONOUNCED DEAD

June 12, 1967 7:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Mercy Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3321 Avondale Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 22, 1902

9. AGE (In years last birthday)

64

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Grocer

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

BENJAMIN GREEN

14. MOTHER'S MAIDEN NAME

SARAH

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

218-14-6169

17. INFORMANT

MRS. BESSIE GREEN, 3321 AVONDALE AVENUE #15

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) ~~HEART FAILURE~~

Hypertensive and arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 12, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

6/13/67

23C. NAME OF CEMETERY or CREMATORY

SHAAREI TFILOH

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Salomonson Bros.

RECEIVED BY OFFICE

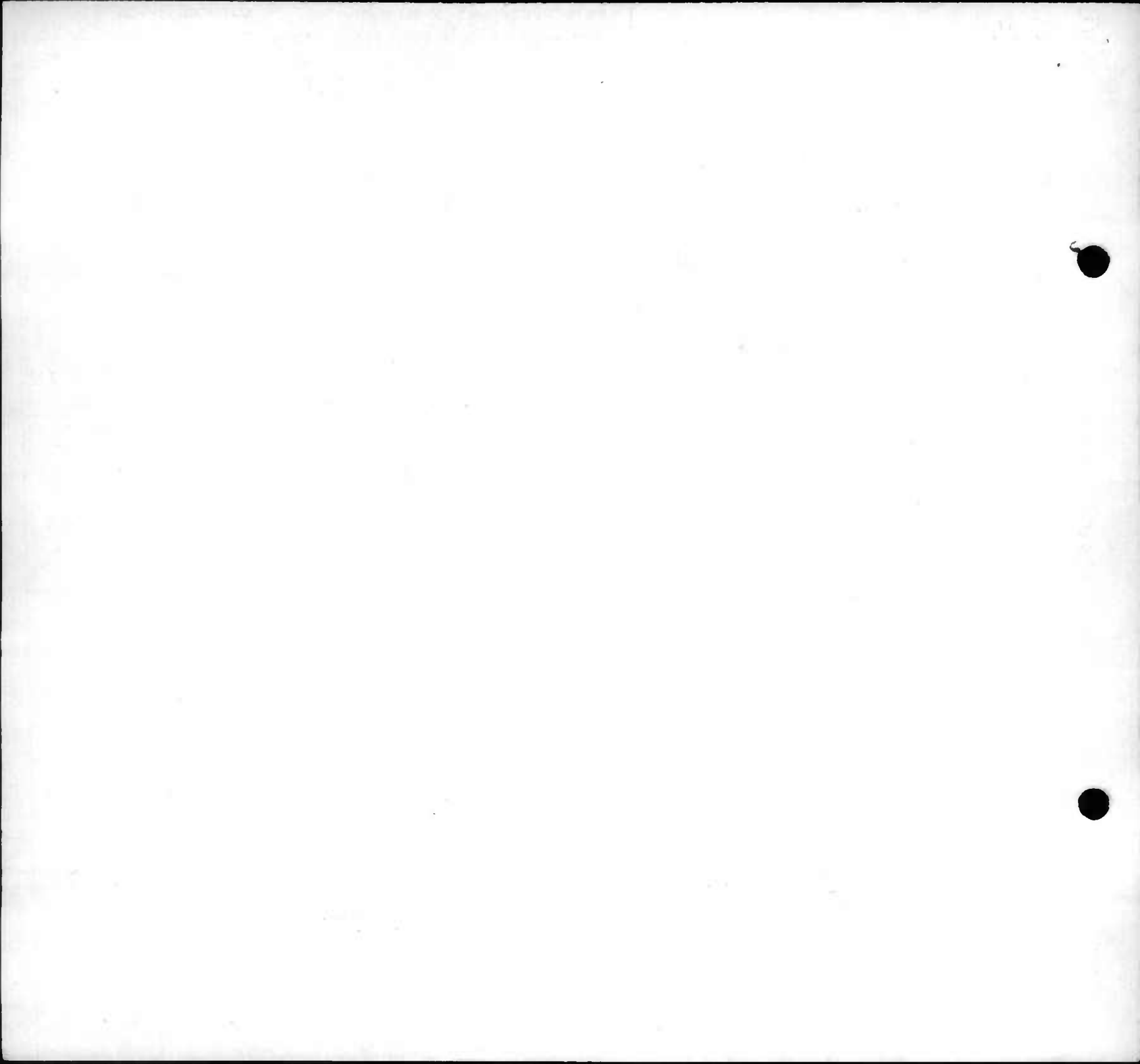
RECEIVED BY OFFICE

RECEIVED BY OFFICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

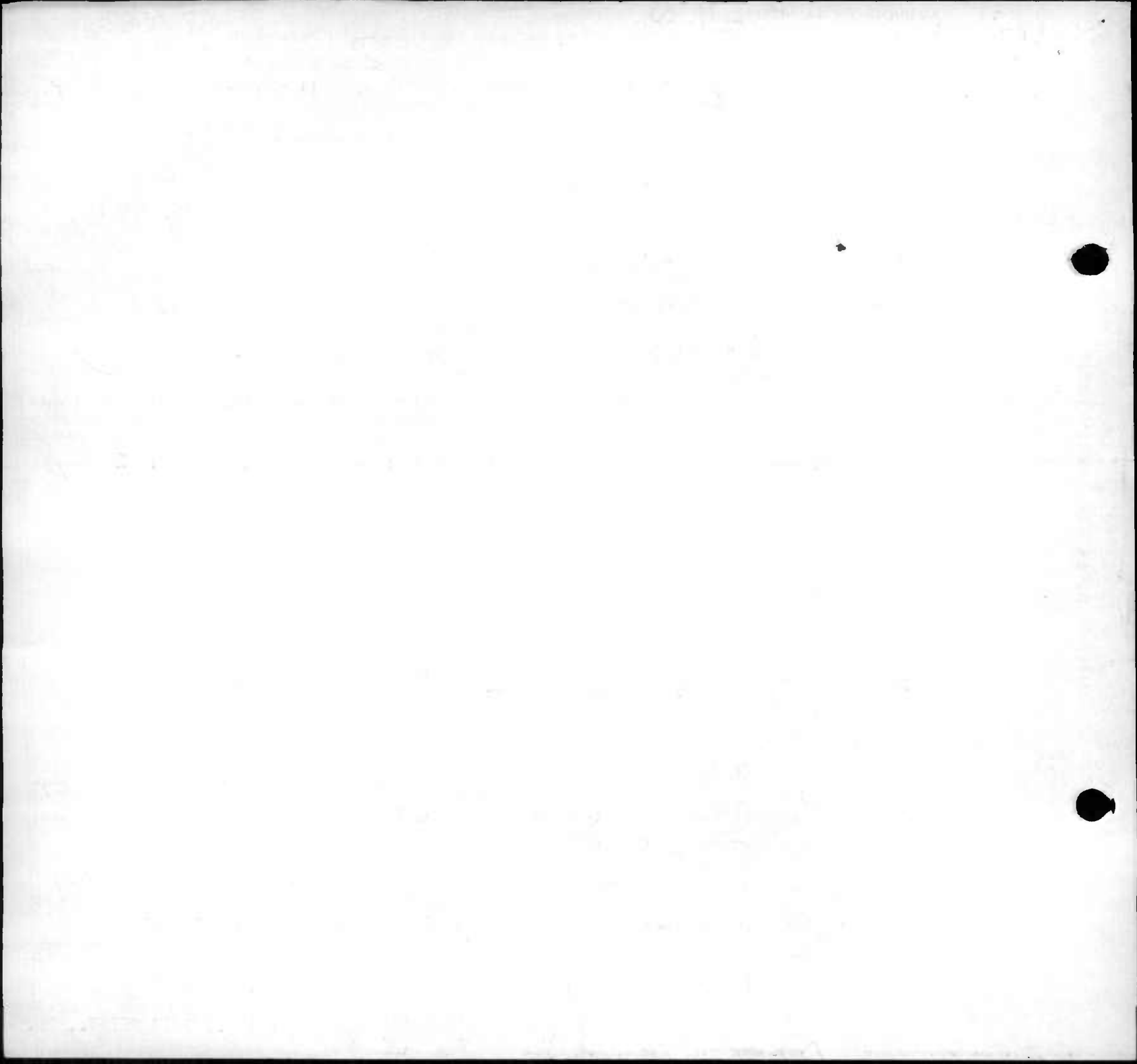
BALTIMORE CITY HEALTH DEPARTMENT									
67 5828					CERTIFICATE OF DEATH		Registered No. 67 5828		
1. NAME OF DECEASED (Type or Print) REBECCA COHEN					2. DATE AND HOUR OF DEATH June 12, 1967 11:15 A. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF (If not in hospital or institution, give street address or location) House in the Pines Belvedere Nlrsing Home 90 W. Belvedere Avenue					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-20 D. STREET ADDRESS (If rural, give location) 7111 Park Heights Avenue Apt 702				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph Margosin					14. MOTHER'S MAIDEN NAME Esther Esterson				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. Ellis Cohen-7111 Park Heights Avenue				ADDRESS Apt 702
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. H A S H D Heart Block					INTERVAL BETWEEN ONSET AND DEATH 1 day 10 7 am				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/13 19 38 to 6/12 19 67 , that (I) (we) last saw the deceased alive on 6/12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Israel Zinberg					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED June 12, 1967	
23C. PHYSICIAN'S NAME (Type) Israel Zinberg					23D. ADDRESS M.D. 4000 W. Northern Parkway				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 13/67		24C. NAME of CEMETERY or CREMATORY Chizuk Amuno			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967			25B. NAME OF REGISTRAR R. L. G. G. G.			25C. FUNERAL DIRECTOR Sol Levinson & Bros Inc. 6010 Reist. Rk			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

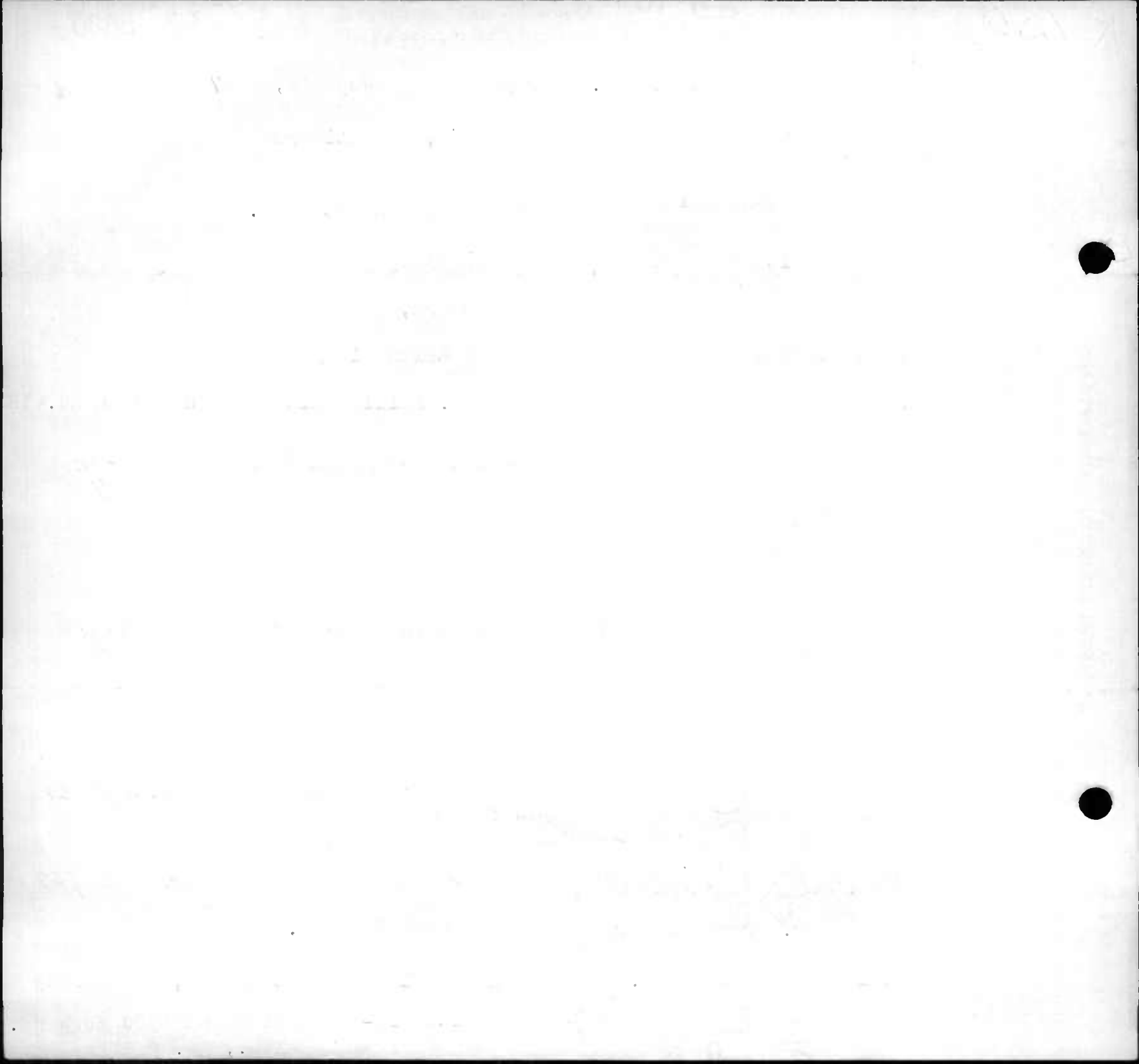
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5829	
BIRTH NO. 67 5829		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 6-11-1967 6:45 P.M.	
1. NAME OF DECEASED (Type or Print) KOPALD SOLOMON MAH		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		A. STATE MARYLAND B. COUNTY Balto. Co.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GEN. HOSPITAL 49		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00	
5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		D. STREET ADDRESS (If rural, give location) 6938 MARSUE DR., APT 1A	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		9. AGE (In years last birthday) 65	
10B. KIND OF BUSINESS OR INDUSTRY Food MARKET		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME MORRIS KOPALD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		14. MOTHER'S MAIDEN NAME MATILDA FINK	
16. SOCIAL SECURITY NO. 212-10-7822		17. INFORMANT ADDRESS NORTH CHARLES GEN. HOSP. CHART	
18. 340.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bacterial meningitis		INTERVAL BETWEEN ONSET AND DEATH 2-3 days	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		20A. AUTOPSY? (Yes or No) No	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (1) (this hospital) attended the deceased from 6-10-1967 to 6-11-1967, that (1) (we) last saw the deceased alive on 6-11-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Juan F. Olerman		23B. DATE SIGNED 6-11-1967	
23C. PHYSICIAN'S NAME (Type) JOSEPH BLUM		23D. ADDRESS 1115 North Calvert St.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/13/67	
24C. NAME OF CEMETERY or CREMATORY HAR ZION TIFERETH ISRAEL		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Refs E. G. Taylor	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 5830		67 5830		67 5830	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Catherine F. Kearny			June 12, 1967 5 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
90 Gould Convalesarium			Md. Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			53-00		
			D. STREET ADDRESS (If rural, give location)		
			301 Dumbarton Rd.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
female	white	widowed	6/9/1885	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
homemaker				Newark, New Jersey	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
John McLaren			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
no					Mrs. Philip Smith 301 Dumbarton Rd. #12
18. 334 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
			(A) Cerebral arteriosclerosis		3+2yr.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Epilepsy due to encephalitis		6yr.
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work Not White At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 1964 to Jan 12, 1967, that (I) (we) last saw the deceased alive on Jan 6, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			M.D. Attending Phys. Med. Director Staff Phys.		23B. DATE SIGNED
Frederick J. Vollmer			<input checked="" type="checkbox"/>		Jan 13 1967
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Dr. Fred Vollmer			6100 York Rd.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6/15/67		Cem. of the Holy Sepulchre East Orange, New Jersey	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 19 1967		Robert E. Finkbeiner		Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-12429 67 5831		CERTIFICATE OF DEATH		Registered No. 67 5831	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BABY FREDERICK, Larry Eugene		2. DATE AND HOUR OF DEATH 6/13/67 3A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 6C			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 26-01			
		D. STREET ADDRESS (If rural, give location) 5604 ALBANE PLAC			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6/13/67	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 25/60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME LARRY E. FREDERICK		14. MOTHER'S MAIDEN NAME Dorothy Kizbler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Larry E. Frederick 5604 Albane Place	
18. 761.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Immaturity (22 wks) (B) DUE TO Premature Sep. of Placenta (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 2:35 AM 6/13/67 to 3 AM 6/13/67 that (I) (we) last saw the deceased alive on 6/13-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John M. Haws		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) John M. Haws		23D. ADDRESS 201 NORTH CALVERT ST. BALTO-MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-15-67		24C. NAME OF CEMETERY OR CREMATORY Family Cemetery	
24D. LOCATION (City, town, or county) (State) Lynchburg, Virginia		25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Philip E. French	
25C. FUNERAL DIRECTOR ADDRESS 1211 Chesaco Ave.					

Union Memorial Hospital

Larry E. Frey

Society of Friends

Committee of Friends
(25 members)

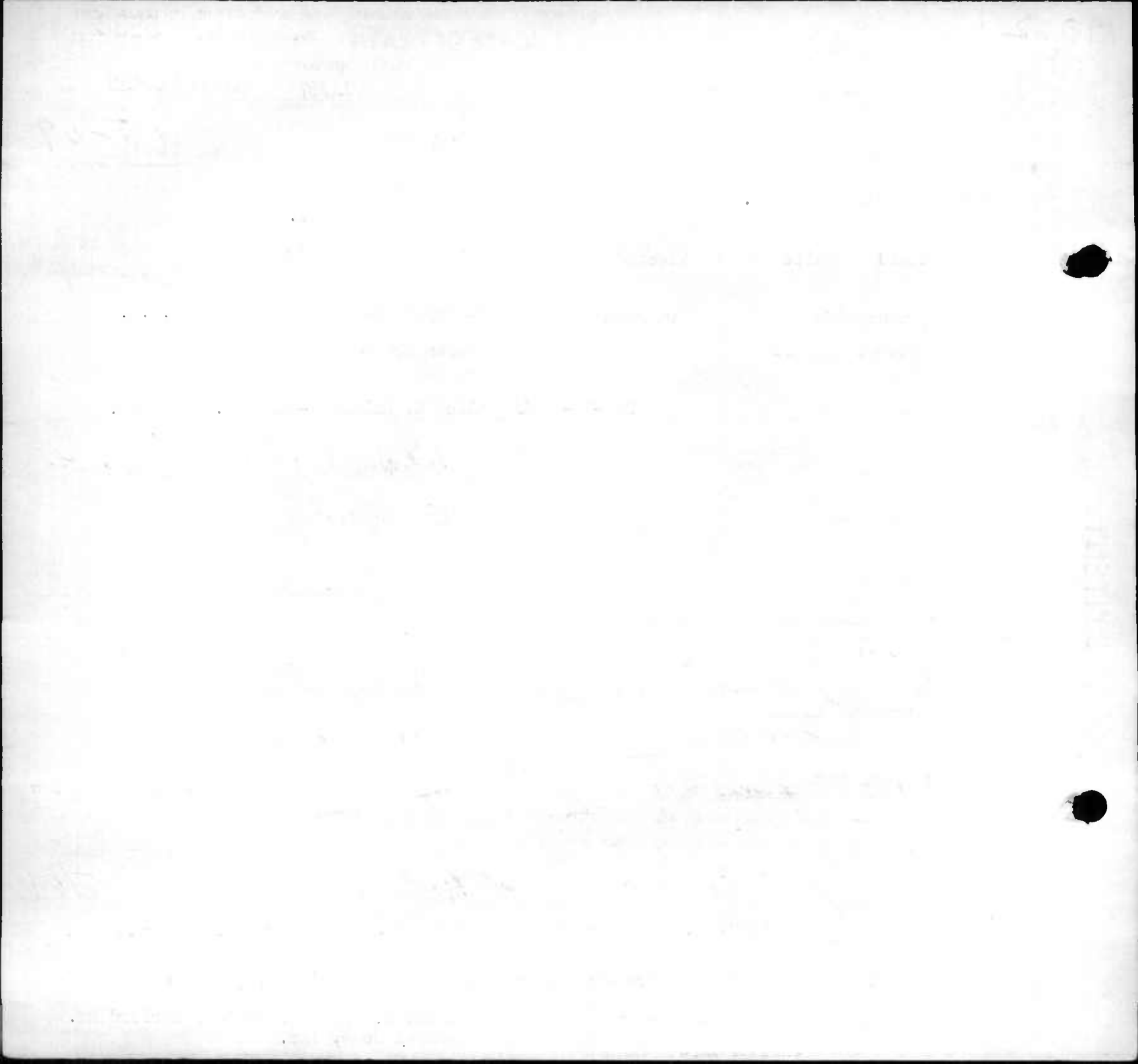
John M. Hays
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John M. Hays
John M. Hays

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5832	
BIRTH NO. 67 5832							
M.E. CASE NO. 67 5832							
1. NAME OF DECEASED (Type or Print) MARY EDNA McCracken				2. DATE AND HOUR OF DEATH 6/14/67 about 4 PM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1633 Northwick Rd.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1633 Northwick Rd.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 5/29/90	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Fassett				14. MOTHER'S MAIDEN NAME Susan Brown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 200-26-7471A		17. INFORMANT ADDRESS Alice E. Halwig - 1000 E. Lake Ave.			
18. 430.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 19 67 to June 19 67 , that (I) (we) last saw the deceased alive on June 8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE J. Palmisano M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 6/15/67			
23C. PHYSICIAN'S NAME (Type) Joseph F. Palmisano M.D.				23D. ADDRESS 6608 Loch Raven Blvd, Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/17/67		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert C. Altenburg		25C. FUNERAL DIRECTOR ADDRESS Robert C. Altenburg - 6009 Harford Rd. Funeral Home, Inc.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5833	
BIRTH NO. 67 5833		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) PHILLIPS WALLACE D		2. DATE AND HOUR OF DEATH JUNE 14 1967 9:50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 23 MELROSE AVE.					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-25-95	9. AGE (In years last birthday) 72	10. Under 1 Yr. Months Days Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION WORKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME MOSE Phillips		14. MOTHER'S MAIDEN NAME FLORIDA SHEETS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 233 10 4829		17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS	
18. 434.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Hypertension - Emphysema Bronchopneumonia - Cor pulmonale		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 13 1967 to JUNE 14 1967 that (I) (we) last saw the deceased alive on JUNE 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George Angov		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-14-67	
23C. PHYSICIAN'S NAME (Type) GEORGE ANGOV		23D. ADDRESS M.D. CATON & WILKENS AVE. BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/17/67		24C. NAME OF CEMETERY OR CREMATORY McAdams Ridge	
24D. LOCATION (City, town, or county) (State) HOWARD COUNTY MD					
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Sullivan		25C. FUNERAL DIRECTOR E.S. MacNabb	
				ADDRESS 301 Frederick Rd Baltimore MD	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5834		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Mrs. Claire Taggart		6/15/67 2:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Hood Convalescent Home - Inc.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 28-04	
FULL NAME OF HOSPITAL OR INSTITUTION 90		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 5313 EDMONDSON AVE	
5. SEX F.	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1/13/1889
9. AGE (In years last birthday) 78		10. CITIZEN OF WHAT COUNTRY? U. S. A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWSPAPERS		10B. KIND OF BUSINESS OR INDUSTRY RET.	
11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ANDREW JOHNSTON		14. MOTHER'S MAIDEN NAME JESSIE COULBAUGH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT CLAIRE T. HEIL		ADDRESS	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Respiratory failure DUE TO (B) Cerebro Vascular Accident DUE TO (C) Atherosclerosis - Cerebral	
INTERVAL BETWEEN ONSET AND DEATH minutes 36 hours		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Previous Cerebral Hemorrhage & Hemiplegia 3 yrs	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1967 to 6/15 1967 that (I) last saw the deceased alive on 6/15 1967 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) did (did) view the body after death.			
23A. SIGNATURE James Nolan		23B. DATE SIGNED 6/17/67	
23C. PHYSICIAN'S NAME (Type) J J NOLAN		23D. ADDRESS 1 Mallow Hill Rd Balt Md 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/18/67	
24C. NAME OF CEMETERY or CREMATORY LEASOCK CEMETERY		24D. LOCATION (City, town, or county) (State) LANCASTER CO. PA.	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1967		25B. NAME OF REGISTRAR R. E. HARRIS	
25C. FUNERAL DIRECTOR E. S. MAGNABB		ADDRESS 301 FREDERICK RD 21228	

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THE COURT REPORTER

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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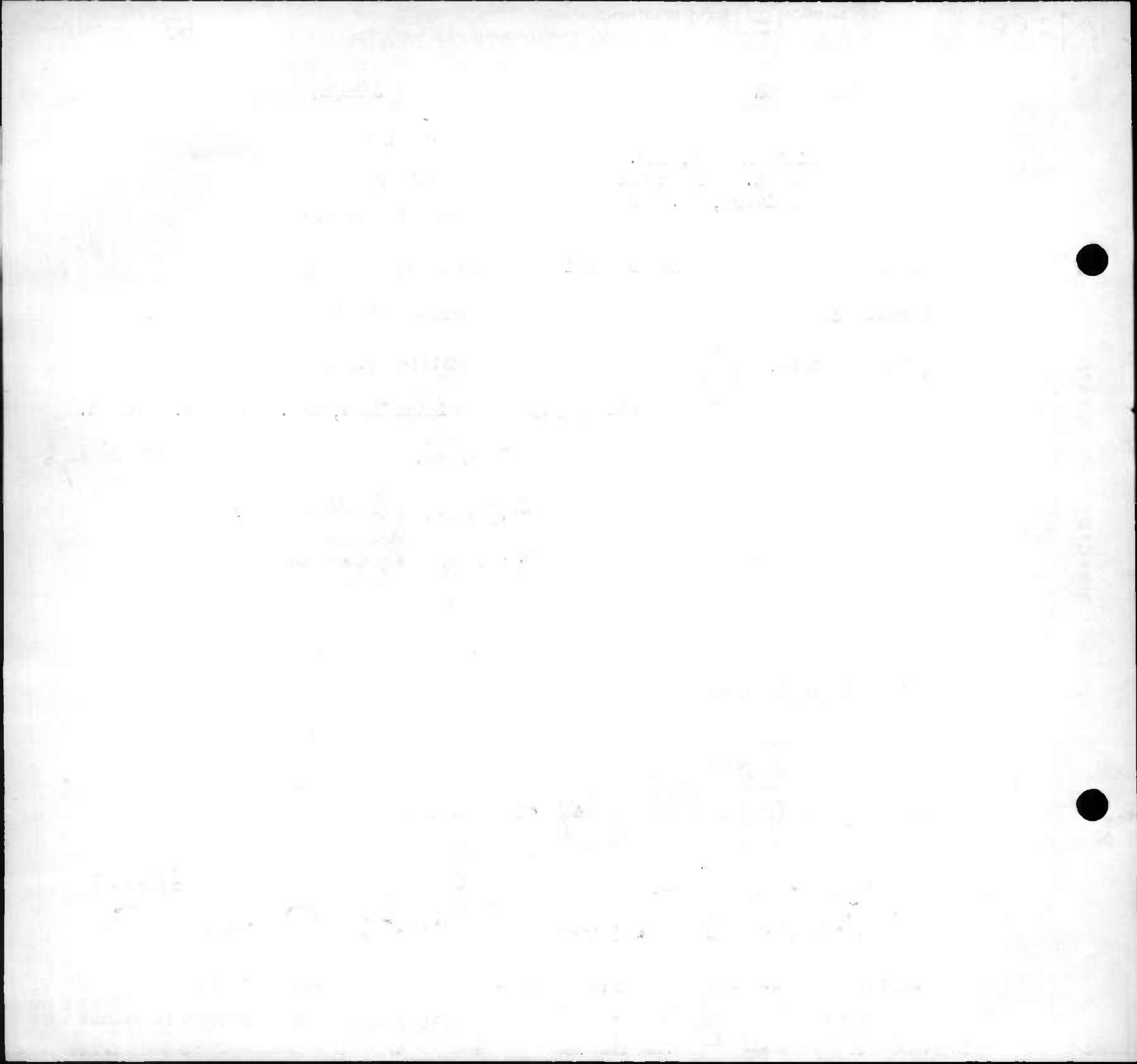
BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 67 5835	
BIRTH NO. 67 5835				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) GEORGE E. FOGLER				6/17/67 11:00P.M. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL 900 CATON AVENUE BALTIMORE, MARYLAND				A. STATE MARYLAND			
				B. COUNTY 25-04			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 604 PONTIAC AVENUE			
5. SEX MALE	6. RACE CAUC	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 2/20/10	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN Laundry		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert B. Fogler				14. MOTHER'S MAIDEN NAME Sarah Heckrotte			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ST. AGNES HOSP. RECORDS		ADDRESS 900 CATON	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				Ventricular Fibrillation (A) DUE TO Acute myocardial infarction (B) DUE TO Arteriosclerotic cardiovascular disease (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/17 19 67 to 19 that (I) (we) last saw the deceased alive on 6/17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Robert B. Fogler</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/18/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 621 67		24C. NAME OF CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie, A. A. Co. Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR <i>Robert B. Fogler</i>		25C. FUNERAL DIRECTOR 58 Md City		ADDRESS 237 Pat. Ave.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

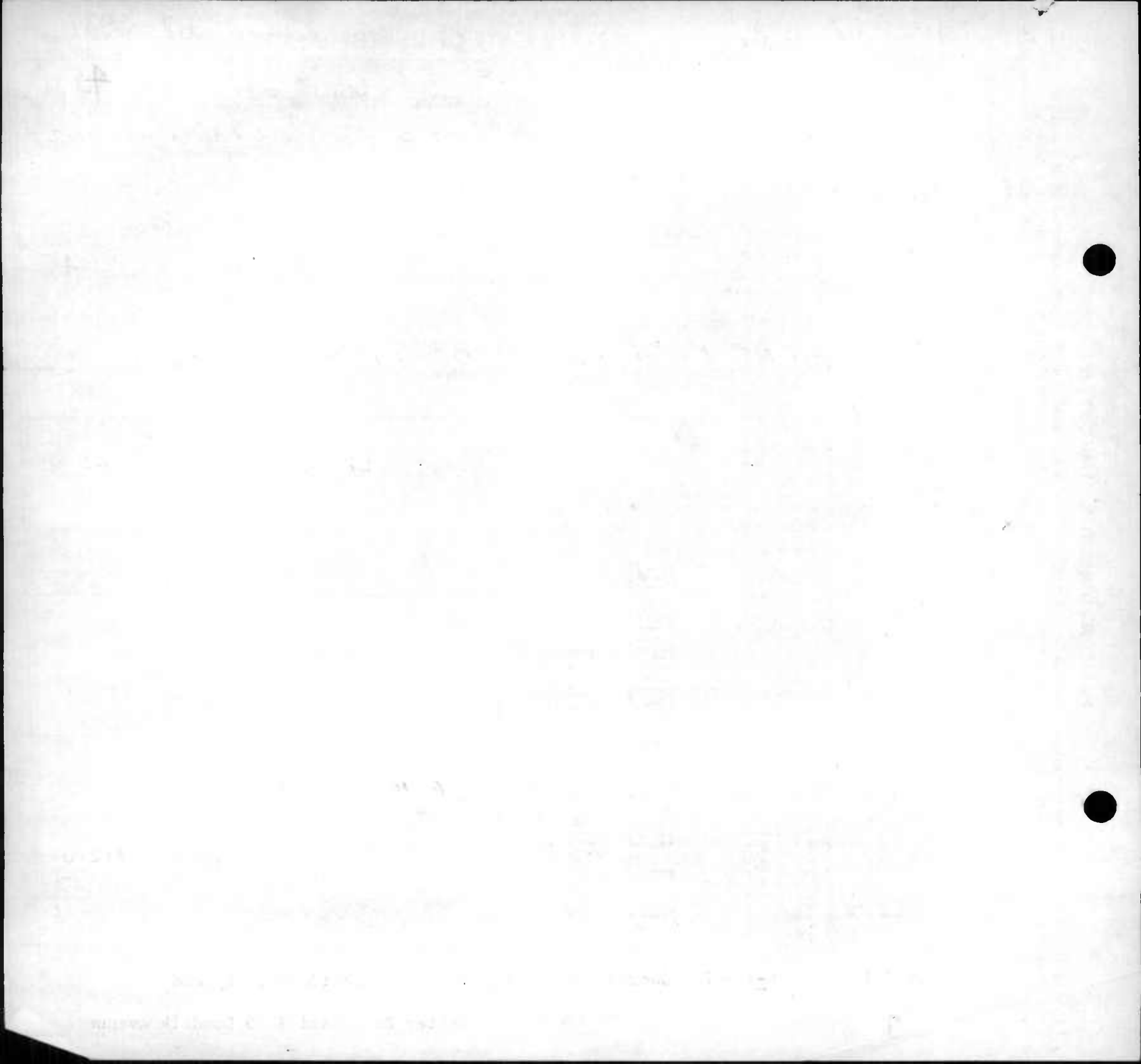
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5836</u>	
BIRTH NO. <u>67 5836</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Cora Mason</u>			
2. DATE AND HOUR OF DEATH <u>6/16/67</u> <u>4</u> AM.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90</u> <u>Midtown Home, Inc.</u> <u>808 St. Paul Street</u> <u>Baltimore, Md. 21202</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>11-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>808 ST Paul Street</u>			
5. SEX <u>Female</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>10/10/73</u>	9. AGE (In years last birthday) <u>90</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Warsaw Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Moses Delano</u>		14. MOTHER'S MAIDEN NAME <u>Hallie V. Packett</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216 03 5456 A</u>		17. INFORMANT <u>Midton Home, Inc. 808 St. Paul St.</u>	
18. <u>433.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>C.V.A.</u> (B) DUE TO <u>Arteriosclerotic C.V.</u> (C) <u>Heart Block</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>10/15</u> <u>1964</u> to <u>6/13</u> <u>1967</u> . that (I) (we) last saw the deceased alive on <u>6/13</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Joseph S. Blum</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6/16/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM</u>		23D. ADDRESS <u>1115 N. CALVERT ST</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-18-67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Warsaw Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Warsaw Virginia</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 19 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Walter Dabrowski 1005 Dundalk Avenue</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5837	
BIRTH NO. 67-12598 5837		CERTIFICATE OF DEATH			
M.E. CASE NO. 67 5837		1. NAME OF DECEASED (Type or Print) Baby Boy BLAKE		2. DATE AND HOUR OF DEATH 6.15.67 2:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PARKVILLE B. COUNTY PARKVILLE MD 53-00 C. CITY OR TOWN (If outside city limits, write RURAL and give township) PARKEVILLE MD 53-00 D. STREET ADDRESS (If rural, give location) 2704 BURRIDGE RD.	
5. SEX M	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6.14.67	9. AGE (In years last birthday) 23 Mos.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 23 45
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ROBERT P. BLAKE			
14. MOTHER'S MAIDEN NAME BETTY L. BLAKE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) 776X I Prematurity				INTERVAL BETWEEN ONSET AND DEATH 23 hrs. 45 mins	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO (B) DUE TO (C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6.14.1967 to 6.15.67 19 67 that (I) (we) last saw the deceased alive on 6.15.1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Khan M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 6.15.67	
23C. PHYSICIAN'S NAME (Type) MISBAH KHAN				23D. ADDRESS University Hosp. Balt.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-16-67		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetary	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. FUNERAL DIRECTOR ADDRESS Walter Dabrowski 1005 Dundalk Avenue			
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Walter Dabrowski		25C. FUNERAL DIRECTOR ADDRESS 1005 Dundalk Avenue	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the Chief Medical Examiner's Office if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5838	
BIRTH NO. 67 5838		CERTIFICATE OF DEATH		2:00 PM	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN LEISTNER		2. DATE AND HOUR OF DEATH 6-15-67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 8-02		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL		D. STREET ADDRESS (If rural, give location) 2135 E. NORTH AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 8-5-09	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tile Setter		10B. KIND OF BUSINESS OR INDUSTRY Floor Covering		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOSEPH LEISTNER		14. MOTHER'S MAIDEN NAME JENNIE / FOOS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-09-9236		17. INFORMANT Ellen E. Skarda 8314 Philadelphia Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) E. coli bacteremia		CAUSE OF DEATH E. coli bacteremia		INTERVAL BETWEEN ONSET AND DEATH 4 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic lung disease		DUE TO Chronic lung disease		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture hip		DUE TO Fracture hip		7 days	
19A. DATE OF OPERATION 16/9/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fractured hip		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 7	
21D. TIME OF INJURY (APPROX.) 6 8 67 AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fall after blocking out	
22. I certify that (I) (this hospital) attended the deceased from 6/8 1967 to 6/15 1967, that (I) (we) last saw the deceased alive on 6/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harmon J. Eyre		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/15/67	
23C. PHYSICIAN'S NAME (Type) Harmon J. Eyre		23D. ADDRESS 601 N Broadway Balt Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-16-67		24C. NAME OF CEMETERY or CREMATORY Belair Memorial Cemetery	
24D. LOCATION Belair, Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Philip G. Cruch 1211 Chesebro Ave	

2. coli bacterium

chronic lung disease

fracture hip

6/19/57 fractured hip No start

6/12/57 ✓ fall after slipping out

✓ 6/12/57 ✓
Harmon J. Eyre
Harmon J. Eyre

5-1245

67 5839

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5839

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PHILLIP A. SIEGLEIN

2. DATE AND HOUR PRONOUNCED DEAD

June 16, 1967

9:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

435 South Gilmore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

August 20, 1900

9. AGE (In years
last birthday)

66

10. Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CARMAN

10B. KIND OF BUSINESS OR INDUSTRY

RAILROAD

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE SIEGLEIN

14. MOTHER'S MAIDEN NAME

ELIZABETH -

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL
SECURITY NO.

213-10-5477

17. INFORMANT

ADDRESS

Mary Sieglein 435 S. Gilmore St.

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springgate, M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

June 17, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

6-20-67

23C. NAME OF CEMETERY or CREMATORY

LORRAINE PARK

23D. LOCATION

Woodlawn

(City, town, or county)

(State)

Md.

24A. DATE RECEIVED BY HEALTH DEPT.

JUN 19 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Geo. L. Schwab Funeral Home
Francis W. Miller 2101 Frederick Ave.

August 20, 1970

Received

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

ORIGINAL

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

1
G-300

67 5840

BALTIMORE CITY HEALTH DEPARTMENT

67 5840

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CHARLOTTE GADDY				2. DATE AND HOUR PRONOUNCED DEAD June 16, 1967 11:50 P.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 36 Franklin Square Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 19-01 D. STREET ADDRESS (If rural, give location) 338 W. Bruce Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MARCH 26-1912	9. AGE (In years last birthday) 55		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY PUT FAMILY		11. BIRTHPLACE (State or foreign country) WADESBORO N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK FLOWERS				14. MOTHER'S MAIDEN NAME HANNAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-22-5398		17. INFORMANT LEONARD GADDY ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 443X1 Hypertensive cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 17, 1967 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify) Burned		23B. DATE 6/21/67		23C. NAME OF CEMETERY or CREMATORY MAH AUBURN		23D. LOCATION (City, town, or county) (State) BALTIMORE	
24A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		24B. NAME OF REGISTRAR Robert E. Taylor		24C. FUNERAL DIRECTOR Marshall P. Hays		ADDRESS 635 N. GILMAN ST	

March 25-1912

220-1-2318 James G. Day

James G. Day, 220-1-2318

1
G. 125

67 5841

BALTIMORE CITY HEALTH DEPARTMENT

67 5841

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ALBERT J. GIBSON				2. DATE AND HOUR PRONOUNCED DEAD June 16, 1967 7:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1924 Pennsylvania Avenue				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1924 Pennsylvania Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED (specify) SINGLE		8. DATE OF BIRTH APRIL 21-1906 61	9. AGE (In years last birthday) If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Gibson				14. MOTHER'S MAIDEN NAME BERTHA POWELL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII 218-01-4425		16. SOCIAL SECURITY NO. 218-01-4425		17. INFORMANT ADDRESS Ferna Clifford 1458 N. Carey St			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E976X1 Gunshot wound of head (A) DUE TO II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1924 Pennsylvania Avenue 14-03			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) Unk Unk		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> Shot self in head		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ACTUAL SIGNATURE Werner U. Spitz M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> 6/16/67							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/26/67		23C. NAME of CEMETERY or CREMATORY BALTONATIONAL		23D. LOCATION (City, town, or county) (State) BALTIMORE	
24A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		24B. NAME OF REGISTRAR Robert E. Farkner		24C. FUNERAL DIRECTOR ADDRESS Wm. Henry & Sons 638 N. Gilman St			

N8364

St

1915-1916
1917-1918
1919-1920

1915-1916
1917-1918
1919-1920

1915-1916
1917-1918
1919-1920

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. 67 5842
BIRTH NO. 67 5842		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MAGGIE M. HILL			2. DATE AND HOUR OF DEATH JUNE 15-1967 1:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2803 HILLSDALE AVE				A. STATE MD		B. COUNTY 28-03				
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE						
				D. STREET ADDRESS (If rural, give location) 2803 HILLSDALE AVE						
5. SEX FE	6. RACE COLORED	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW		8. DATE OF BIRTH OCT 14 1876		9. AGE (In years last birthday) 90		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) A.A. Co. MD				12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME GEORGE BROOKS				14. MOTHER'S MAIDEN NAME Unknown						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT JOHN H. HILL				ADDRESS 2803 HILLSDALE AVE		
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Cerebral Hemorrhage 48 hrs (B) DUE TO Hypertensive Cardiocascular 2 yrs. (C) Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Senility										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 6-13-1967 to 6-15-1967 , that (I) (we) last saw the deceased alive on 6-14-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE J. Bradshaw Higgins				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-16-69				
23C. PHYSICIAN'S NAME (Type) J. Bradshaw Higgins				23D. ADDRESS 2243 Madison Ave						
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6/18/67		24C. NAME OF CEMETERY OR CREMATORY Mt CALVARY		24D. LOCATION (City, town, or county) (State) Brooklyn-Baltimore MD 21225				
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Thomas H. Higgins		ADDRESS 638 N. Gilmor St				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5843	
BIRTH NO. 67 5843					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) ANNA P. MOORE			2. DATE AND HOUR OF DEATH 6-15-67 4:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Midtown Nursing Home			A. STATE B. COUNTY Md. Balt.		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) 21-02		
5. SEX F			6. RACE W		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W			8. DATE OF BIRTH 6-4-84		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress			10B. KIND OF BUSINESS OR INDUSTRY Laundry		
11. BIRTHPLACE (State or foreign country) Germany			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Recher			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. —		
17. INFORMANT Harry A. Moore - Glou			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X1			CAUSE OF DEATH (A) Cardio Respiratory Failure (B) Ac Congestive Failure (C) Art. EVHD		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/24/66 19 to 6/15/67 that (I) (we) lost saw the deceased alive on 6/15/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William Appleford				23B. DATE SIGNED 6/16/67	
23C. PHYSICIAN'S NAME (Type) William Appleford				23D. ADDRESS 5501 Paint Heights Dr	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-19-67		24C. NAME OF CEMETERY or CREMATORY Western Cem	
24D. LOCATION (City, town, or county) (State) Balt. Md.		24E. NAME OF REGISTRAR John E. Fisher		24F. FUNERAL DIRECTOR John J. Cowan & Son Inc	
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Balt. Md.	

6-11-2

Constitution
of the
United States
of America

Article I
Section 1

Section 1
All legislative
Powers herein
granted shall be
vested in a
Congress of the
United States
which shall
consist of a
Senate and
House of
Representatives

Article II
Section 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5844		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5844	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) TAYLOR Samuel			2. DATE AND HOUR OF DEATH 6-14-67 10:25 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Charles General Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 7-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Md. 21205 D. STREET ADDRESS (If rural, give location) 912 N. MADERIA ST		
5. SEX MALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED , DIVORCED (specify)	8. DATE OF BIRTH 7-28-85	9. AGE (In years last birthday) 81 YRS.	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer			11. BIRTHPLACE (State or foreign country) Baltimore MARYLAND		12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME Samuel Taylor			14. MOTHER'S MAIDEN NAME Alice Sunderland		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 218-05-9762		17. INFORMANT ADDRESS Chart North Charles General Hospital
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Myocardial Infarction Acute Pulmonary Edema			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-14 19 67 to 6-14 19 67 , that (I) (we) last saw the deceased alive on 6-14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose Y. Ortiz				23B. DATE SIGNED 6-14-67	
23C. PHYSICIAN'S NAME (Type) JOSE Y. ORTIZ				23D. ADDRESS NORTH CHARLES GEN. HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/19/67		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	
				ADDRESS 2601 E. Madison St.	

7-28-82

Wright

Shirley Taylor

Place

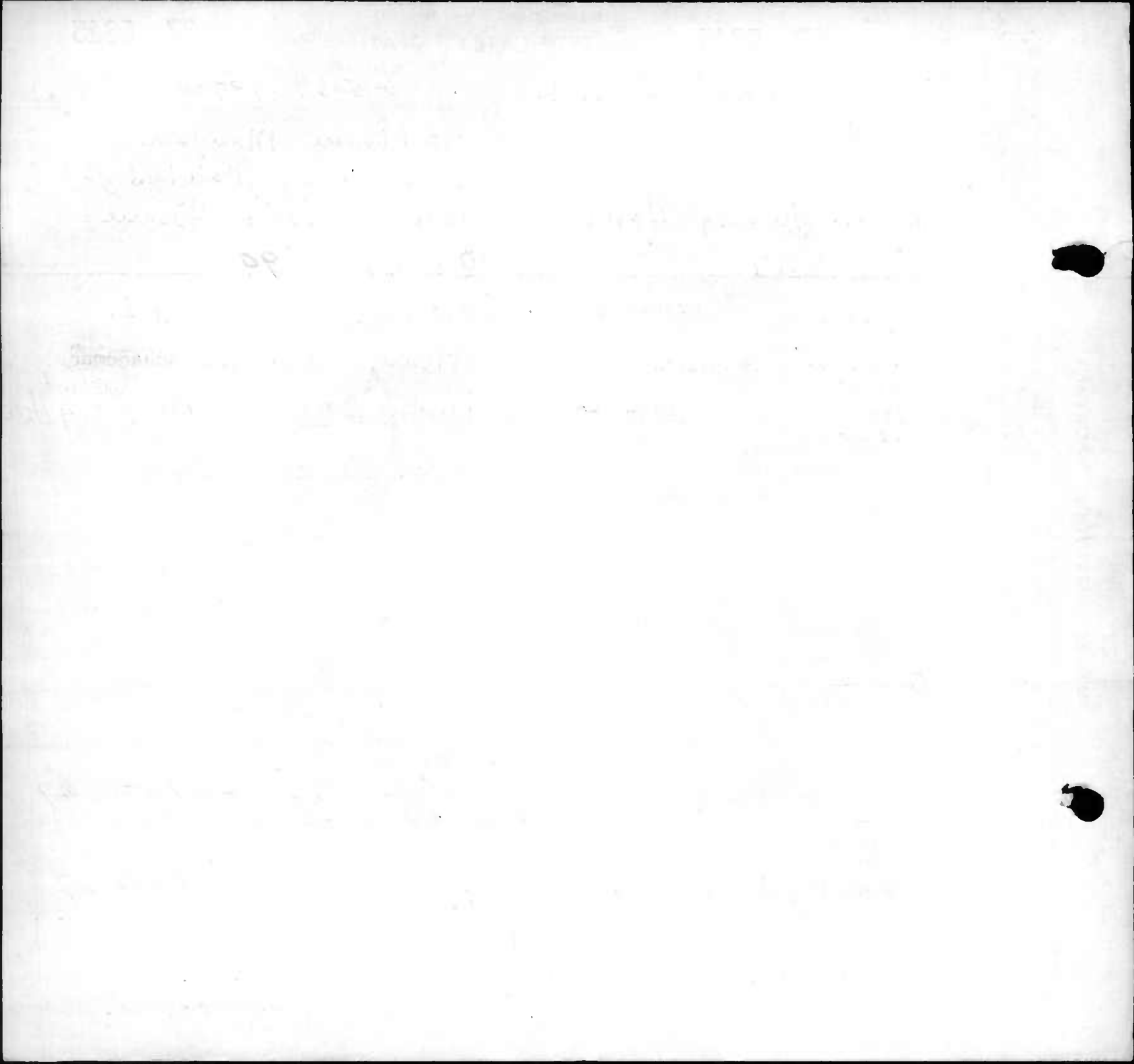
North Street

10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5845		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5845	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Henry John Dreisch Sr.		2. DATE AND HOUR OF DEATH 6-15-67 9:30 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Baltimore, Maryland.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Maryland 8-03	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Dukeland Nursing Home		D. STREET ADDRESS (If rural, give location) 1511 Montford Avenue		E. DATE OF BIRTH 10-8-1876	
5. SEX M	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. AGE (in years last birthday) 90	9. Under 1 Yr. Months Days	10. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10B. KIND OF BUSINESS OR INDUSTRY Franke Constr.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME M. JOSEPH DREISCH		14. MOTHER'S MAIDEN NAME Mary Schageman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-05-0489		17. INFORMANT Dorothy Becker / P. Foster Duke Land Nursing Home	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.01		CAUSE OF DEATH (A) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO			
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 11-11-1966 to 6-15-1967, that (I) lost saw the deceased alive on 6-13-1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Percival P. Smith M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23B. DATE SIGNED 6-15-67		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/19/67		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 5846		CERTIFICATE OF DEATH	
M.E. CASE NO.		Registered No. 67 5846	
1. NAME OF DECEASED (Type or Print) Ida M. Hughes		2. DATE AND HOUR OF DEATH 6-17-67 9²⁵ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 90 BOLTON HILL NURSING HOME		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-38	
D. STREET ADDRESS (If rural, give location) 3535 Liberty Heights Ave			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify)	8. DATE OF BIRTH 11-27-1881
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 85
11. BIRTHPLACE (State or foreign country) Rochester, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Hughes		14. MOTHER'S MAIDEN NAME Mary Jane Gott	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-05-2693	
17. INFORMANT Frank A. Smith-3535 Liberty Hghts. Avenue		ADDRESS	
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CVA right		INTERVAL BETWEEN ONSET AND DEATH April 1967	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hypertensive C.V. disease year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW OLD INJURY OCCUR?	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/14 1967 to 6/17 1967 , that (I) (we) last saw the deceased alive on 6/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE al [Signature] M.D.		23B. DATE SIGNED 6/17/67	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT M.D.		23D. ADDRESS 2 E Real St 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-20-1967	
24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR Ellsworth Armacost		ADDRESS 4600 Liberty Hghts. Ave	

OFFICE OF THE COMMISSIONER

NEW YORK

January 1, 1910

Dear Sir:

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5847	
CERTIFICATE OF DEATH					
BIRTH NO. 67 5847		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Boyd Pugh			2. DATE AND HOUR OF DEATH 6/15/67 11:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE 42			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 5321 Cuthbert Avenue		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 12-17-1917	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Salesman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Adrian, Washington	
13. FATHER'S NAME Glenn Pugh			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2			16. SOCIAL SECURITY NO. 52-055-8285		17. INFORMANT ADDRESS Roanoke, Va # 24018 Barbara Harrison-4326 Cresthill Dr.
18. 581.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CIRRHOSIS OF LIVER ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Alcoholism			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO 20+ years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6/13/67 19 to 6/15/67 19 that (1) (we) last saw the deceased alive on 6/15 19 and that in (my) () opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Abe Levy				23B. DATE SIGNED 6/15/67	
23C. PHYSICIAN'S NAME (Type) ABE LEVY				23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-20-67		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Ellsworth Armacost-4600 Liberty Hgts. Ave			

100-1000

100-1000

100-1000

100-1000

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100-1000

100-1000

100-1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
67 5848 CERTIFICATE OF DEATH

Registered No. 67 5848

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JENNIE JAFFE

2. DATE AND HOUR OF DEATH

6-16-67 1 12¹⁰ A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

SINAI HOSP. of BALTIMORE, INC
42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND BALT. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location)

8343 Church LA

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

M

8. DATE OF BIRTH

12-15-90

9. AGE (In years last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

LITHUANIA

12. CITIZEN OF WHAT COUNTRY?

? USA

13. FATHER'S NAME

PeLOVITZ - MENDEL

14. MOTHER'S MAIDEN NAME

GISSA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

HUSBAND

ADDRESS

SAME

18. 420.14-260X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

ABAND CVA

(B) DUE TO

ASCUD E OLD MI.

(C) DUE TO

Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

1 month

10 years

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

DIABETES MELLITUS

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (ratify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-17 1967 to 6-16 1967, that (I) (we) last saw the deceased alive on 6-15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ceslie Abramowitz

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6-16-67

23C. PHYSICIAN'S NAME (Type)

Ceslie Abramowitz

M.D.

23D. ADDRESS

SINAI HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

6-16-1967

24C. NAME of CEMETERY or CREMATORY

MT. CARMEL

24D. LOCATION

BALTO.

(City, town, or county)

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

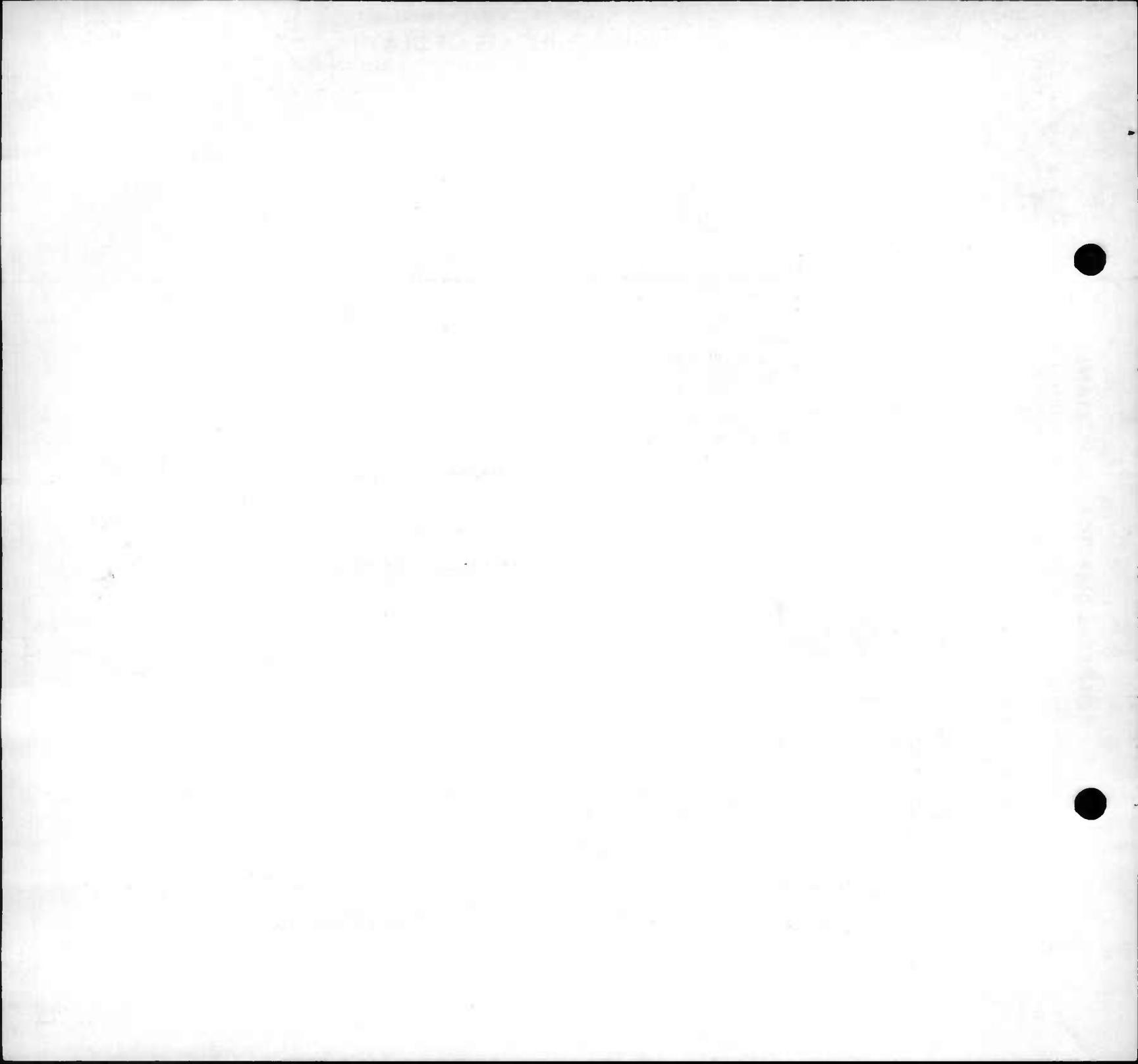
25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

Sylvan S. Lewis & Son - GARRISON, MD

ADDRESS



1
D-150

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

67 5849

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5849

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

AMELIA DAFFIN

2. DATE AND HOUR PRONOUNCED DEAD

June 12, 1967 7:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44
99 Union Memorial Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1101 E. Belvedere Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Sept. 26, 1893

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

Bugle Laundry

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George J. Emperle

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-03-5080

17. INFORMANT

ADDRESS

Mrs. Hilda Killmond-3203 Kenyon Ave.-21213

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic heart disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK

NOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 12, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-15-67

23C. NAME of CEMETERY or CREMATORY

Moreland Memorial Park

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

John C. Miller Inc. - 6415 Belair Road - 21206

100-000000

100-000000

H 200

67 5850

BALTIMORE CITY HEALTH DEPARTMENT

67 5850

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ELMER B. HICKS				2. DATE AND HOUR PRONOUNCED DEAD June 17, 1967 5:25 A. <small>M.</small>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3029 Woodland Avenue				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-16 D. STREET ADDRESS (If rural, give location) 3029 Woodland Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9-25-09	9. AGE (In years last birthday) 57	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Robert Hicks			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 318-14-9819		17. INFORMANT Catherine Hicks 5059 Woodland Ave		
18. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 17, 1967							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6-17-67		23C. NAME of CEMETERY or CREMATORY Arbutus Mem/ Park.		23D. LOCATION (City, town, or county) (State) Arbutus, Maryland	
24A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.			ADDRESS

9-25-09 27

Married

Married

11.2.2

Robert M. H.

Married

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

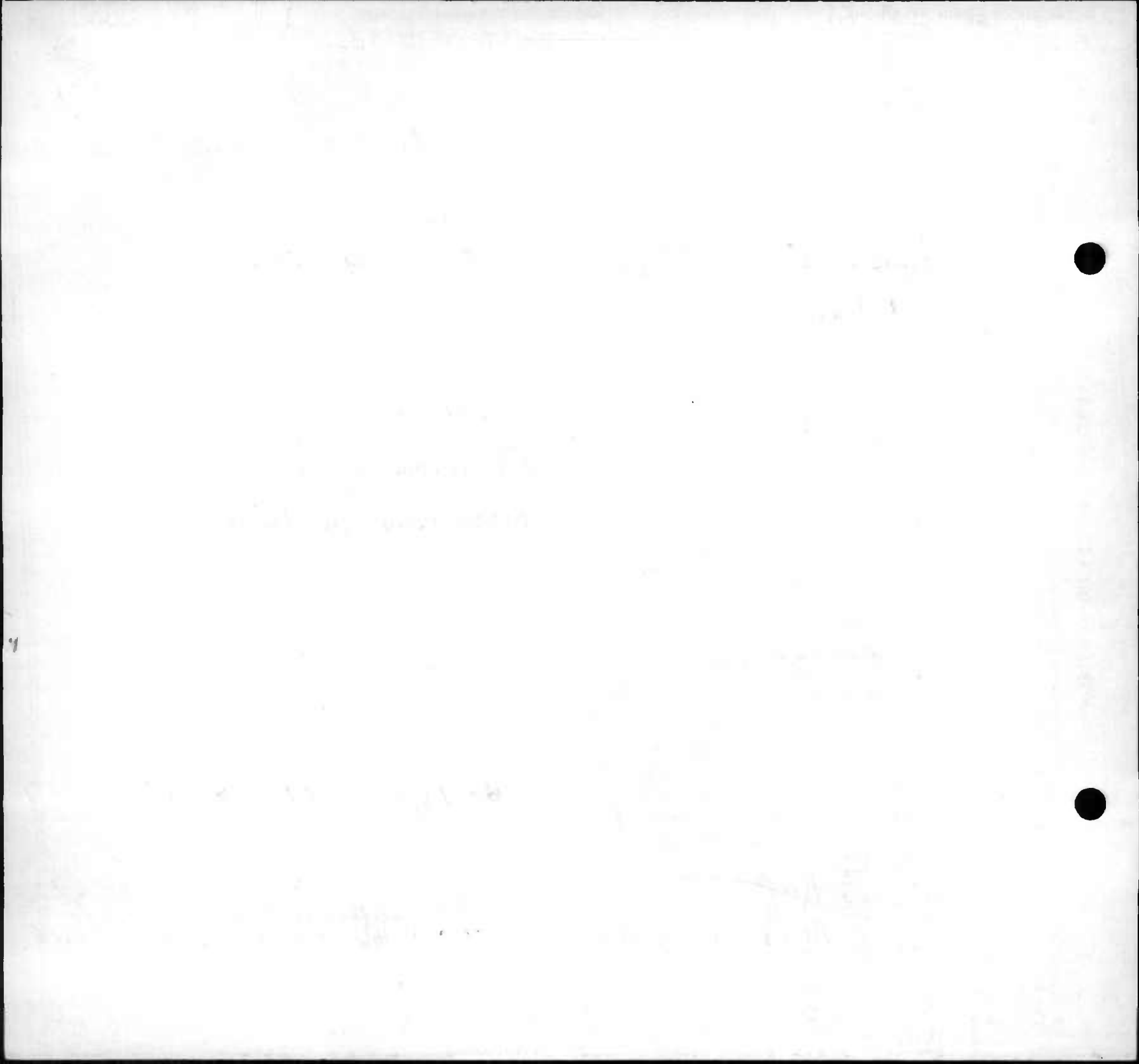
49-48-84 1		67 5851		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5851	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) MARGARET REDDICK				6-16-67 12:20 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224				A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1409 PRESTMAN ST. # 21217 PRESSTMAN			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 3-16-27	9. AGE (In years last birthday) 40	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CLARENCE BROWN				14. MOTHER'S MAIDEN NAME MARGARET KING			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 002.1 I MASSIVE HEMOPTYSIS PULMONARY TUBERCULOSIS 40 MOS				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH 5 min			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-13 19 67 to 6-16 19 67 , that (I) (we) last saw the deceased alive on 6-16 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Bruce G. Whipple</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-16-67	
23C. PHYSICIAN'S NAME (Type) DR. BRUCE G. WHIPPLE				23D. ADDRESS BCH-4940 EASTERN AVENUE, BALTIMORE, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-19-67		24C. NAME OF CEMETERY or CREMATORY West Lincoln Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>George A. Kiser</i>		ADDRESS 1348 N. Calhoun St.	

Handwritten text at the bottom of the page, possibly a signature or date, which is mostly illegible due to fading. It appears to contain the words "Handwritten" and "1954".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

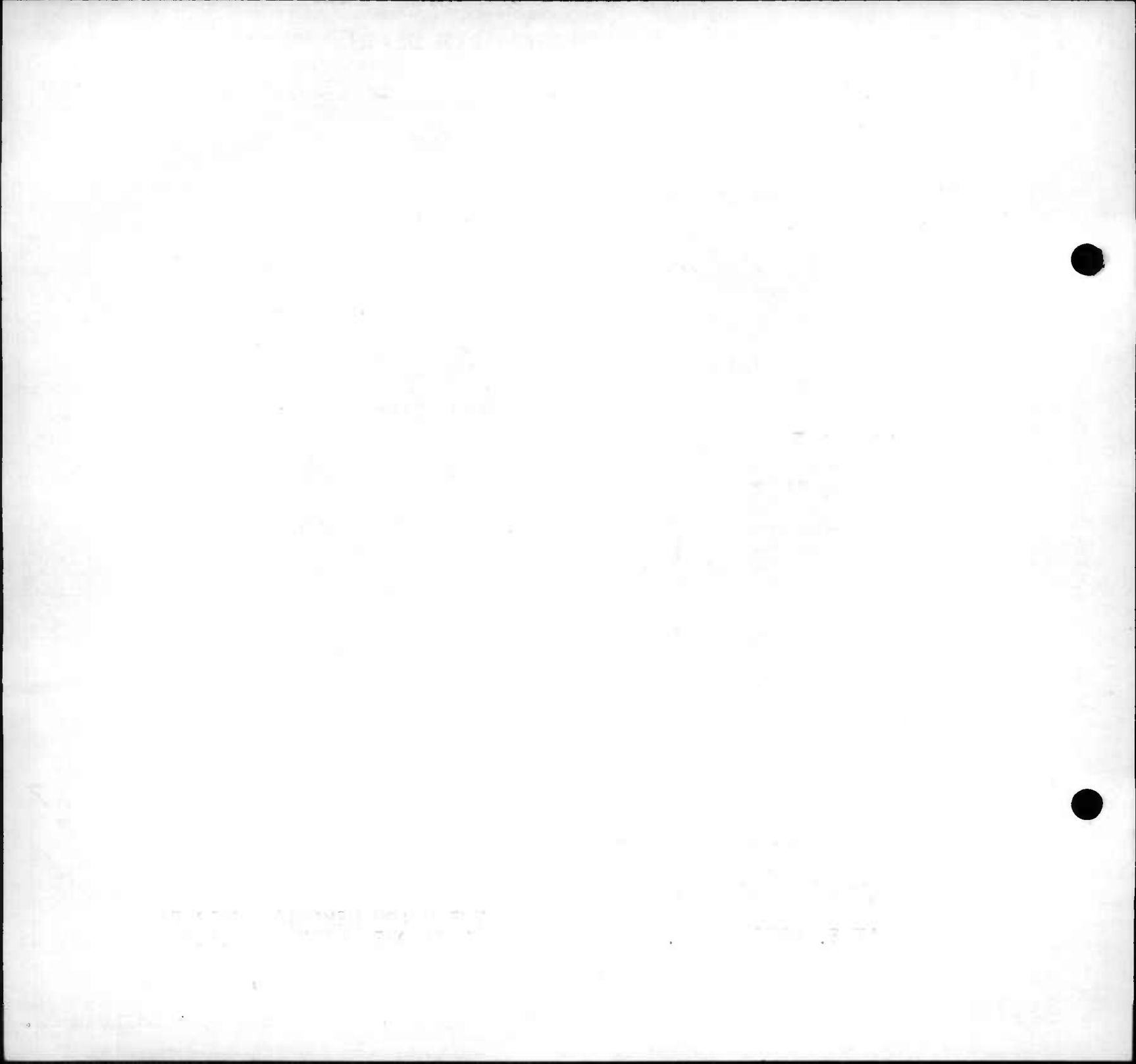
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 5852		CERTIFICATE OF DEATH		67 5852	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) ANDERSON WILLIAM O.			2. DATE AND HOUR OF DEATH 6-15-67 3:00 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland			A. STATE Maryland B. COUNTY 16-07		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 3129 Baker St.		
5. SEX Male	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 5-1-1899	9. AGE (In years last birthday) 68 yrs	10. Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Lucille Anderson Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 163 X I Carcinoma of Lung Metastasis in Brain.			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-13-1967 to 6-15-1967 that (I) (we) last saw the deceased alive on 6-15-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Amjashi			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-15-67
23C. PHYSICIAN'S NAME (Type) ANIL M. JOSHI			23D. ADDRESS Lutheran Hospital of Maryland 730 Ashbluton St. Baltimore 2126		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-19-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk. Arbutus, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Kelson Funeral Home 1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5853		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5853	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mrs. Novella Williams		2. DATE AND HOUR OF DEATH June 17, 1967 12:55A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 12-04			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 439 E 23rd St.			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 12/26/24	9. AGE (in years last birthday) 42	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jim Jenkins			14. MOTHER'S MAIDEN NAME Sudie Williams		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs Martha Willis		ADDRESS 412 E 20th St. Baltimore
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebro-vascular accident 4h (B) Hypertension (C)		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/16 1967 to 6/17 1967, that (I) (we) last saw the deceased alive on 6/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nat E. Watson Jr.				23B. DATE SIGNED 6/17/67	
23C. PHYSICIAN'S NAME (Type) NAT E. WATSON, JR.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL BALTIMORE, MARYLAND 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-21-67		24C. NAME of CEMETERY or CREMATORY Church Cemetery	
24D. LOCATION (City, town, or county) (State) Bethel, North Carolina		25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967			
25B. NAME OF REGISTRAR Robert E. Felt		25C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.			



R. 152

67 5854

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5854

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE A. ROBINSON

2. DATE AND HOUR PRONOUNCED DEAD

6-10-67

6:30 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1128 W. NORTH AVENUE - Amb. Crew #8

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1128 W. North Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
single

8. DATE OF BIRTH

11-9-13

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Eugene Hardin

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Doris Robinson 1128 W. North Avenue

18. 502.07581.1
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cor pulmonale
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Chronic bronchitis and emphysema
DUE TO

(C)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Laennec's cirrhosis

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
m. WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

6-11-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-17, 1967

23C. NAME of CEMETERY or CREMATORY

St. Luke Cem.

23D. LOCATION

(City, town, or county)

(State)

Howard County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Kelson Funeral Home 1348 Calhoun St.

ADDRESS

WALLACE FORBES

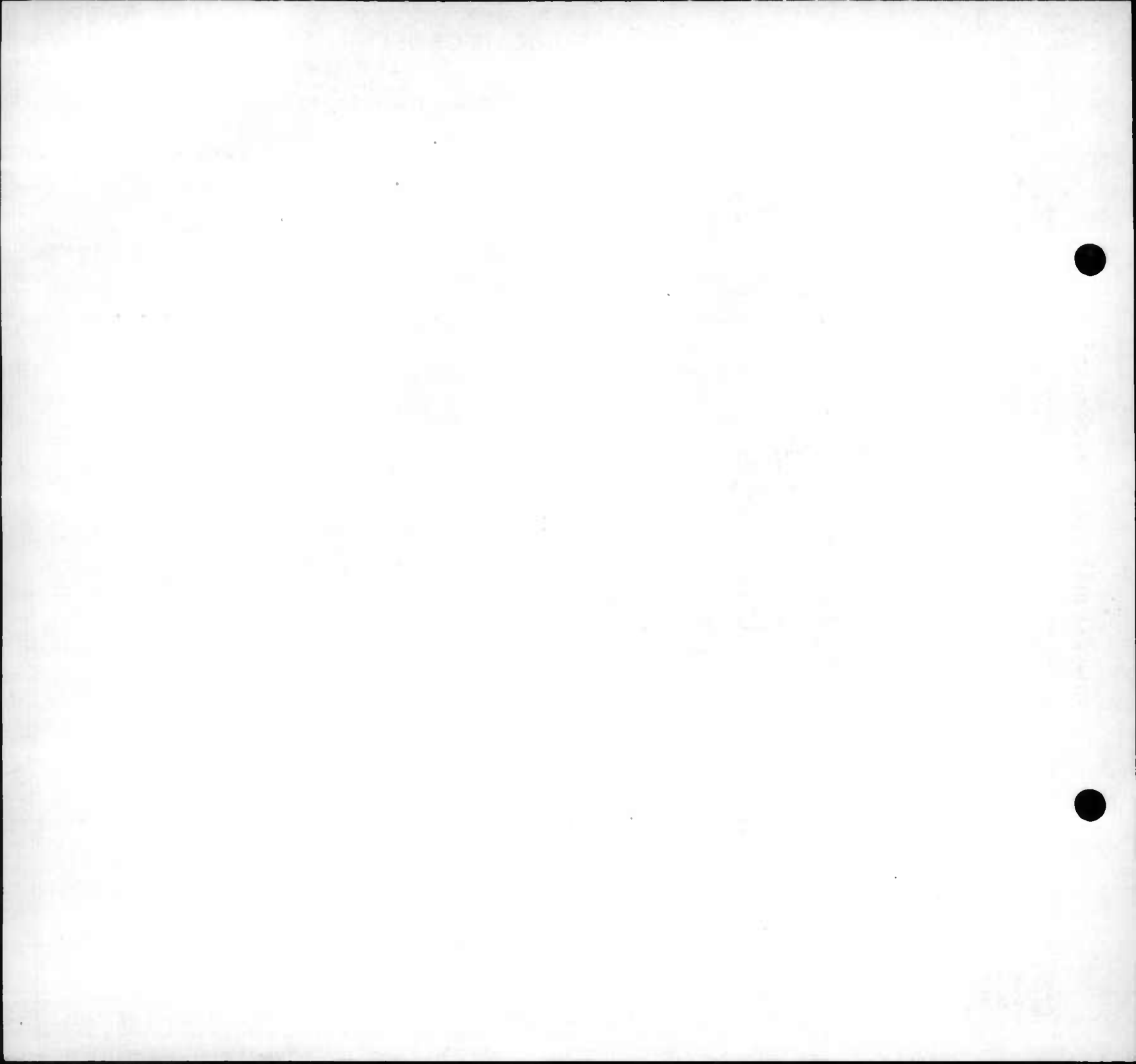
COLLEGE PARK

1955

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5855	
BIRTH NO. 67 5855		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lottie Taylor		2. DATE AND HOUR OF DEATH 6-14-67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 15-02			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1811 Monroe Street Baltimore, Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.		D. STREET ADDRESS (If rural, give location) 1811 1/2 Monroe St.	
5. SEX Female	6. RACE Negroid	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 10-3-91	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md,	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Basfield 1811 Monroe Street	
18. 443 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebral Hemorrhage (Left) DUE TO (B) Hypertensive Cardiovascular Disease DUE TO (C) Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 3 yr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 6-10-64 19 to 6-14-67 19		that (I) (we) last saw the deceased alive on 6-14-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE G. Franklin Phillips		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/16/67	
23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips		23D. ADDRESS M.D. 558 McMechan St. - Balto Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-17-67	24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT					
67 5856 CERTIFICATE OF DEATH				Registered No. 67 5856	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Mrs. SARAH JAY	
2. DATE AND HOUR OF DEATH		June 14, 1967 7:15 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
34 Bon Secours Hospital			Maryland		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
Baltimore			25-31 4427 Frederick Avenue		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
F	W	Widowed	11/29/89	77	Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Own Home		New Jersey	USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Wesley Johnson			NANCY Johnson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		216-10-6218		Glen Burnie, Md. Mrs. Walter Frye, 1124 Nottingham Drive	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
451X I			Rupture of aneurysm of arch of aorta with massive hemorrhage		1 day
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Anterior sclerosis, generalized		years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2				yes	yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from June 14 1967 to June 14 1967, that (1) (we) last saw the deceased alive on JUNE 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Argon Atroc				6/15/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Argon Atroc				Bon Secours Hosp Balto, Md 21223	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		17 June 67		Loudon Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 19 1967		Robert E. Taylor		Kirkley Funeral Home, Glen Burnie, Md.	
				Baltimore, Maryland	

1
B-425

67 5857 BALTIMORE CITY HEALTH DEPARTMENT

67 5857

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CATHERINE M. BELSINGER

2. DATE AND HOUR PRONOUNCED DEAD

June 12, 1967

7:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 4119 Frederick Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4119 Frederick Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

July 6, 1914

9. AGE (In years
last birthday)

53 52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cleaning Lady

10B. KIND OF BUSINESS OR INDUSTRY

Bon Secours Hosp.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Charles Carnes

14. MOTHER'S MAIDEN NAME

Catherine M. Lynch

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Frank J. McKenna 902 Calwell Rd. Balto. Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While at
work

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion

resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 12, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

June 17, 1967

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cem.

23D. LOCATION

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

G. Truman Schwab 3512 Frederick

ADDRESS

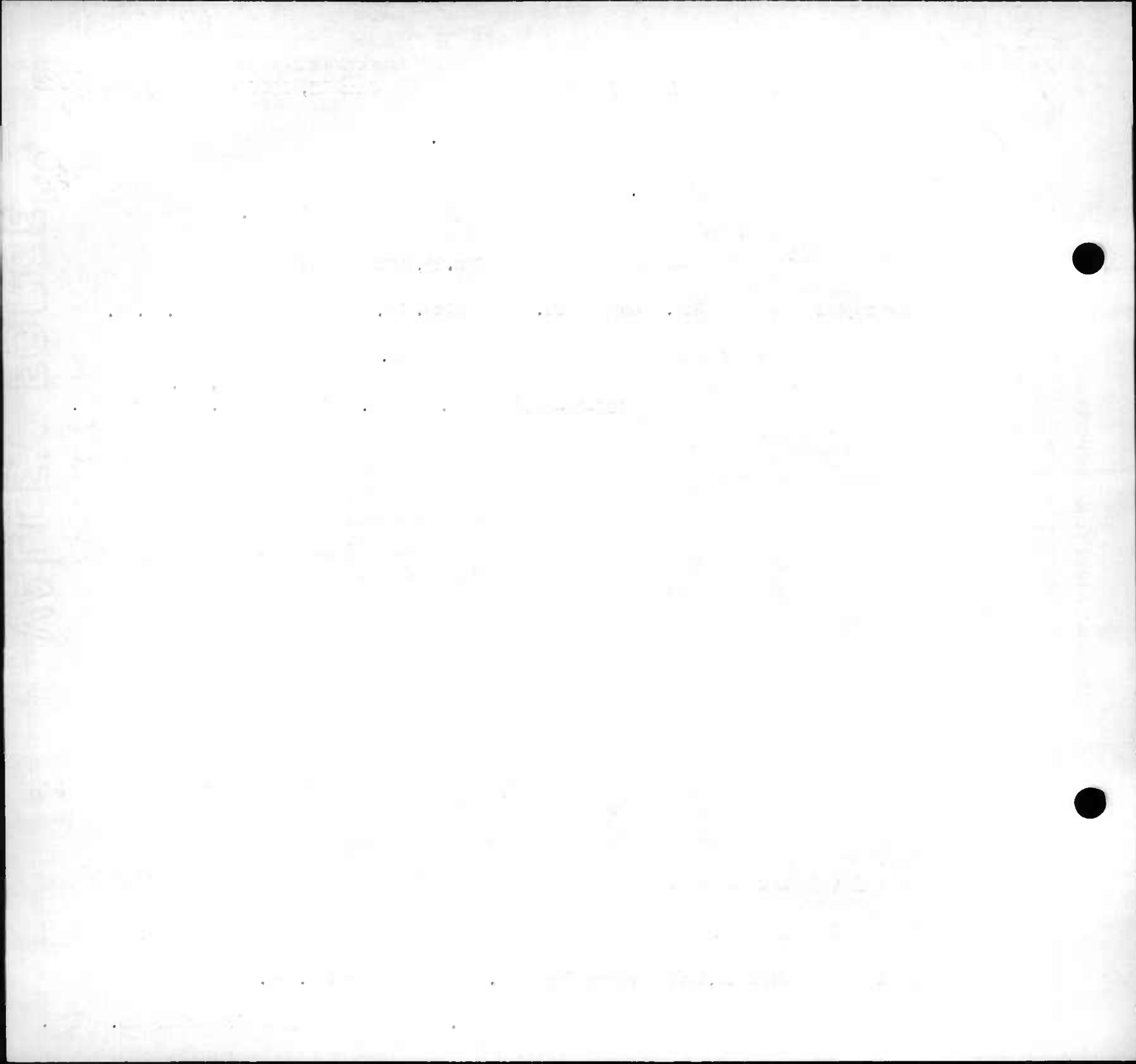
Ave. Balto.

WALLEY FORM

111 PAGE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5858	
67 5858				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Doris Mae RIX Reinhard		June 12, 1967 1045 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY	
00 3506 Old Frederick Rd.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 20-07	
D. STREET ADDRESS (If rural, give location)		3506 Old Frederick Rd.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	White	Single	Jan. 23, 1922	45	U. S. A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Stenographer		Gen. Electric Co.		Balto. Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Charles Reinhard		Ethel N. Tucker		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217-16-4246		Catonsville, Md. 21228	
18. 241X1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Coronary Occlusion		Sudden	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Bronchial Asthma			
		(C) E. Pyemney Congestion		10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-17 67 to 6/12 67, that (I) (we) last saw the deceased alive on 6/11 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edwin W. Johnson				23B. DATE SIGNED 6/15/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Elcot W. Johnson				3432 Frederick Ave. Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		June 16, 1967		Loudon Park Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 19 1967		Edwin W. Johnson		G. T. Schab 3512 Frederick Ave. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5859 CERTIFICATE OF DEATH					Registered No. 67 5859				
BIRTH NO. 67 5859					2. DATE AND HOUR OF DEATH 6-15-67 11:05 P.M.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) MATTHEWS, FRANK									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital of Md.					A. STATE B. COUNTY				
					Duland Nursing Home				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore, Maryland / 6-07				
					D. STREET ADDRESS (If rural, give location)				
					1501 Dukeland Ave. St.				
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married (Sep)	8. DATE OF BIRTH 5-5-1904	9. AGE (In years last birthday) 63	10. UNDER 1 Yr. Months: Days:		11. UNDER 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Major Matthews					14. MOTHER'S MAIDEN NAME Jane Bailey				
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-01-8844		17. INFORMANT Hilary Matthews		ADDRESS 1512 W. Louisa St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 493X1 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH				
					(A) Pulmonary embolism (B) Pneumonia (C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH 4 1/2 to 8 days				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) ✓		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? ✓					
22. I certify that (I) (this hospital) attended the deceased from 6-8-1967 to 6-15-1967, that (I) (we) last saw the deceased alive on 6-15-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Nguyen Thi Oanh M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6-15th-1967	
23C. PHYSICIAN'S NAME (Type) NGUYEN THI OANH M.D.					23D. ADDRESS Lutheran Hospital of Maryland				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/19/67		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION Balto. Md.		(State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 319 N. Schrock St.			

1. *Journal of the American Medical Association*

2. *New England Journal of Medicine*

3. *Annals of Internal Medicine*

4. *Journal of the American Academy of Child and Adolescent Psychiatry*

5. *Journal of the American Psychiatric Association*

6. *Journal of the American Geriatrics Society*

7. *Journal of the American Society of Nephrology*

8. *Journal of the American Society of Hypertension*

9. *Journal of the American College of Physicians*

10. *Journal of the American Society of Internal Medicine*

11. *Journal of the American Society of Gerontology*

12. *Journal of the American Society of Geriatric Medicine*

13. *Journal of the American Society of Geriatric Medicine*

14. *Journal of the American Society of Geriatric Medicine*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5860		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5860	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ALBERT A. LAUR		2. DATE AND HOUR OF DEATH JUNE 13, 1967 5 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.	
FULL NAME OF HOSPITAL OR INSTITUTION 00 4219 MARY AVE.		D. STREET ADDRESS (If rural, give location) 4219 MARY AVE.		26-01	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH OCTOBER 24, 1903	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER - RETIRED		10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) BALTO. MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANK LAUR		14. MOTHER'S MAIDEN NAME ANNA ENGEL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-09-3979		17. INFORMANT MRS. HELEN B. LAUR	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of Lung DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 8 years		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-28 19 48 to 6-13 19 67 , that (I) (we) last saw the deceased alive on 6-12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Max R. English				23B. DATE SIGNED 6-15-67	
23C. PHYSICIAN'S NAME (Type) MAX R. ENGLISH				23D. ADDRESS 5713 BELAIR RD BALTIMORE MD. 21206	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-16-67		24C. NAME of CEMETERY MOST HOLY REDEEMER	
24D. LOCATION (City, town, or county) (State) BELAIR RD, BALTO, MD.		25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Farkman	
25C. FUNERAL DIRECTOR J. Shatto Conklin		25D. ADDRESS 5444 BELAIR RD.			

100

100

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-11456 67 5861		CERTIFICATE OF DEATH		Registered No. 67 5861	
1. NAME OF DECEASED (Type or Print) BABY BOY EWING			2. DATE AND HOUR OF DEATH JUNE 12, 1967 3:50 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 21222 Baltimore B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 53-00 2526 LIBERTY PKWY.		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 6-10-67	9. AGE (In years last birthday) 1 3 55	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME KENNETH J. Ewing			14. MOTHER'S MAIDEN NAME SHEILA (SWEETWOOD)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -----	17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE		
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Im maturity ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 27 hrs.		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 10 19 67 to JUNE 12 19 67 , that (I) (we) last saw the deceased alive on JUNE 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cora P. Arellano				23B. DATE SIGNED June 13, 1967	
23C. PHYSICIAN'S (Type) CORA P ARELLANO				23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/67		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Colgate, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home Dundalk, Md.			

BACK DOOR ENTRY

DATE OF BIRTH

SEX

DATE OF DEATH

PLACE OF BIRTH

EDUCATION

RELIGION

TRADE

STATUS

HEIGHT

WEIGHT

HAIR

COLORED (YES/NO)

SCARS

TOOTH

ST. JOHN HOSPITAL, MEMPHIS, TENN.

See Page 1

DATE

TIME

BY

ST. JOHN HOSPITAL

ST. JOHN HOSPITAL

ST. JOHN HOSPITAL, MEMPHIS, TENN.

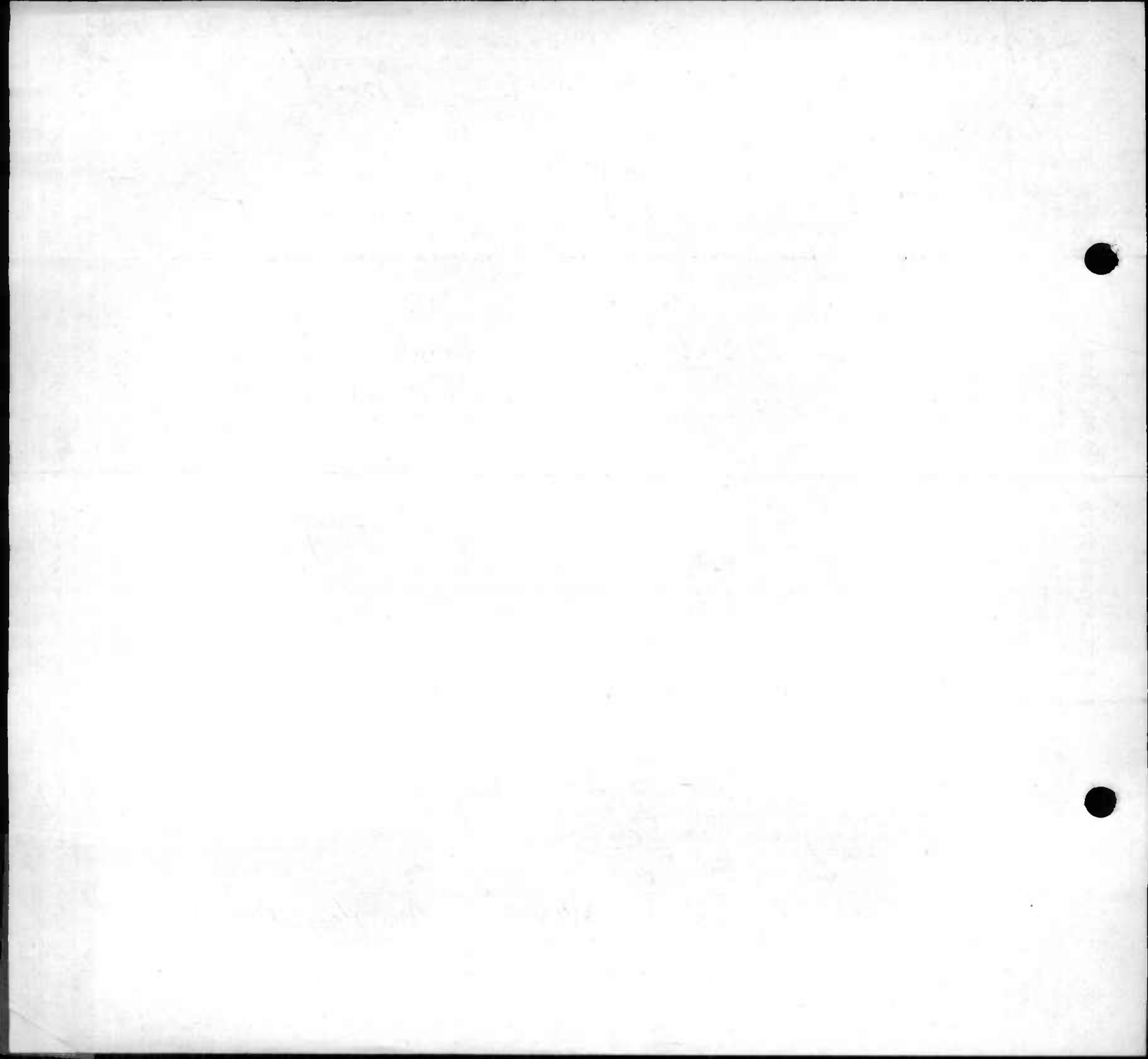
ST. JOHN HOSPITAL

ST. JOHN HOSPITAL, MEMPHIS, TENN.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

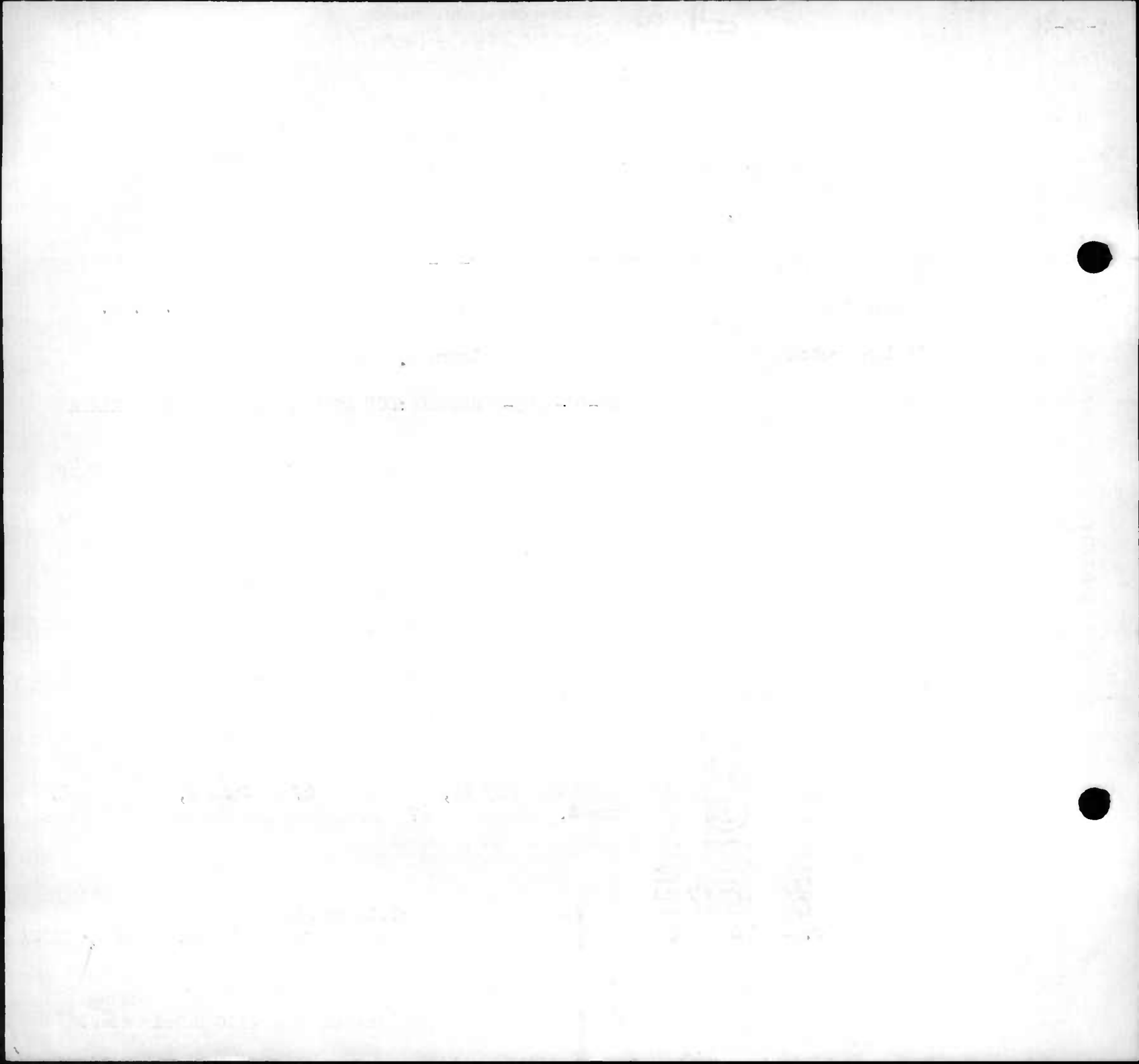
BIRTH NO. 67 5862		BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 67 5862	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mordecai Roland Ewing			
2. DATE AND HOUR OF DEATH June 11 1967 3:30 P		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Maryland General Hospital		A. STATE MD B. COUNTY a. a. Co			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glen Burnie 52-00		D. STREET ADDRESS (If rural, give location) 204 May Court			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH Jan. 16 1906	9. AGE (In years last birthday) 61	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10B. KIND OF BUSINESS OR INDUSTRY PAINT		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Edwin Ewing		14. MOTHER'S MAIDEN NAME Sarah Johnson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO.		17. INFORMANT Medical record. ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Brain infarction		INTERVAL BETWEEN ONSET AND DEATH 5/09/1967-6/11/67	
ANTECEDENT CAUSES		(A) DUE TO Ca of Rt. Lung		June 7 1967	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Ca. of Rt Lung		June 11 1967	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION May 16 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Guarded		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 9 1967 to June 11 1967 , that (I) (we) last saw the deceased alive on June 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Youngsik Moon		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Youngsik Moon		23D. ADDRESS Maryland Gen. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/14/67		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL	
24D. LOCATION (City, town, or county) MD		24E. STATE MD			
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1967		25B. NAME OF REGISTRAR W. B. E. Ewing		25C. FUNERAL DIRECTOR ULURICH FUNERAL HOME - DUNDALK MD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5862					67 5863				
BIRTH NO.					Registered No.				
M.E. CASE NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) <i>AMELIA Marie HORST</i>					2. DATE AND HOUR OF DEATH <i>JUNE 8, 1967 12:10 P. M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>				
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 26-03</i>				
					D. STREET ADDRESS (If rural, give location) <i>3233 Kenyon Avenue 21213</i>				
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>12-23-1884</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William Pretch</i>					14. MOTHER'S MAIDEN NAME <i>Laura W. Winterling</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>212-03-0405-D</i>		17. INFORMANT ADDRESS <i>RECORDS: BCM 4940 Eastern Avenue 21224</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cerebrovascular Accident</i>					INTERVAL BETWEEN ONSET AND DEATH <i>3 Months</i>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Atherosclerosis</i>					<i>Unknown</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Urinary tract infection</i>									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>May 18, 1967</i> to <i>June 8, 1967</i> , that (I) (we) lost saw the deceased alive on <i>June 8, 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>D. Tarsy</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>6-8-1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Daniel Tarsy</i>					23D. ADDRESS <i>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/12/67</i>		24C. NAME of CEMETERY or CREMATORY <i>First United Evan. Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 19 1967</i>		25B. NAME OF REGISTRAR <i>R. E. E. E. E.</i>		25C. FUNERAL DIRECTOR <i>Ulrich Funeral Home</i>			ADDRESS <i>4210 Belair Road.</i>		



R. 361

67 5864

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5864

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)clayton
GRAHAM A RUTHERFORD

2. DATE AND HOUR PRONOUNCED DEAD

6-13-67

9:05 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Street

62-00

D. STREET ADDRESS (If rural, give location)

Rte #16 - Box 512 RFD #2, Box #213

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

May 28, 1903

9. AGE (in years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

T.P. Smith

10B. KIND OF BUSINESS OR INDUSTRY

Aircraft

11. BIRTHPLACE (State or foreign country)

Grayson Co., Virginia

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

William Garfield Rutherford

14. MOTHER'S MAIDEN NAME

NANNIE Lou KALE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

214-18-6500

17. INFORMANT (Brother) 457-4436 ADDRESS

Mr Paul J. Rutherford RFD #2, Box #213
Street, Maryland 21154

18. E823.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bilateral pneumonia and pericarditis
with effusion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) DUE TO
Crushing injury of chest

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Highway

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Northbound spur - Martin Blv'd

160' North of Eastern Boulevard

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year)
4 11 67

21E. INJURY OCCURRED

9:06 PM

m.

WHILE AT
WORKNOT WHILE
AT WORK

X

21F. HOW DID INJURY OCCUR?

Passenger in auto which failed to make
curve

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-13-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

June 16, 1967

23C. NAME of CEMETERY or CREMATORY

Bel Air Memorial Gardens

23D. LOCATION

(City, town, or county)

(State)

Bel Air, Harford Co., Maryland 21014

24A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Joseph William Foster

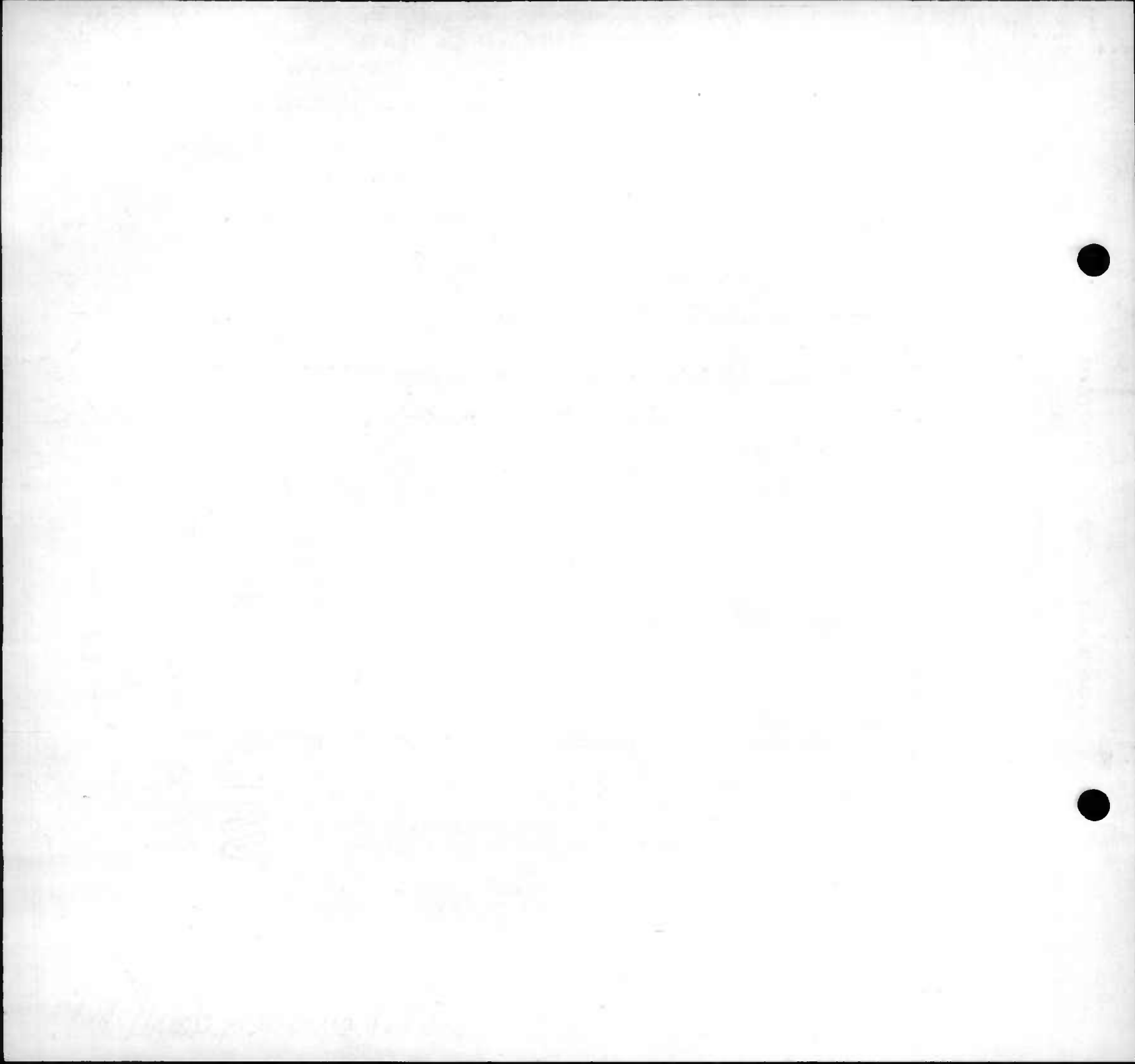
ADDRESS

W. Broadway & Williams St.
Bel Air, Maryland 21014

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5865	
BIRTH NO. 67 5865				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH 6/6/67 5:50PM M.	
1. NAME OF DECEASED (Type or Print) Harvey, William W.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard Co.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Saint Agnes Hospital Caton & Wilkens Aves. 2129				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Savage, Maryland 63-00	
D. STREET ADDRESS (If rural, give location) 206 Washington Street.					
5. SEX 73	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 9/2/93	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Weaver textile mill		10B. KIND OF BUSINESS OR INDUSTRY Emporia Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Wesley Harvey			14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 224-1072964		
17. INFORMANT Benjamin Harvey			ADDRESS Aurilla Pa Rt 2		
18. 465X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Acute pulmonary edema (etiol.?) (B) (C) INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Korbuly				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Suzanna Korbuly-				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 6-10-67		24B. DATE 6-10-67		24C. NAME OF CEMETERY or CREMATORY Savage Cemetery	
24D. LOCATION (City, town, or county) (State) Savage Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Felt	
25C. FUNERAL DIRECTOR Walter A. Korbuly		25D. ADDRESS Aurilla Pa			



1

67 5866

BALTIMORE CITY HEALTH DEPARTMENT

67 5866

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY

C.

SMITH

2. DATE AND HOUR PRONOUNCED DEAD

June 16, 1967

2:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 1738 Webster Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1738 Webster Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

M.

8. DATE OF BIRTH

10-29-98

9. AGE (In years
last birthday)

68

11 Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Foley

14. MOTHER'S MAIDEN NAME

Bridget Coughlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family - Same

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

6/16/67

23A. BURIAL, CREMATION,
REMOVAL (Specify)

23B. DATE

6-19-67

23C. NAME OF CEMETERY or CREMATORY

Glen Haven

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

K. C. Cully - 1300 East Ave.

ADDRESS

WALLEY FORGE

WALLEY FORGE

WALLEY FORGE

WALLEY FORGE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5867	
BIRTH NO. 67 5867		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOSEPH EDWIN LESSNER	
2. DATE AND HOUR OF DEATH JUNE 15, 1967 6:30 A.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 49-40 EASTERN AVENUE BALTIMORE, MARYLAND 21224			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Essex 21221 --005		D. STREET ADDRESS (If rural, give location) 326 MILES RD.	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-13-01	9. AGE (In years lost birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Service Station		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EDWIN Lessner		14. MOTHER'S MAIDEN NAME CLARA WEBER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --		16. SOCIAL SECURITY NO. 213 03 9184		17. INFORMANT ADDRESS RECORDS-BCH 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO MYOCARDIAL INFARCTION (B) DUE TO ARTERIOSCLEROSIS (C) PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 4 days UNKNOWN 2 DAYS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/1 1967 to 6/15 1967, that (I) (we) last saw the deceased alive on 6/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Tarsy				23B. DATE SIGNED JUNE 15, 1967	
23C. PHYSICIAN'S NAME (Type) D. TARSY		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/19/67		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Farkas	
25C. FUNERAL DIRECTOR Bruzdzinski Funeral Home		25D. ADDRESS Bruzdzinski Funeral Home			

10-10-10

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10-10-10

10-10-10

10-10-10

10-10-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-6201		67 5868		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5868	
BIRTH NO. 67-17904 67 5868				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Baby Bay Brooks</i>		2. DATE AND HOUR OF DEATH <i>6/15/67 1230 am</i>	
3. PLACE OF DEATH IN BALTIMORE MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>A.A.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>ANNAPOLIS</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i>				D. STREET ADDRESS (If rural, give location) <i>16 PAROLE STREET 21-41</i>			
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>NEVER MARRIED</i>		8. DATE OF BIRTH <i>5-13-67</i>	9. AGE (In years last birthday) <i>---</i>	If Under 1 Yr. Months Days Hours Min. <i>2</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE MD.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>ROGER PARKER</i>				14. MOTHER'S MAIDEN NAME <i>RUTH BROOKS</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>760.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO <i>Cardiorespiratory arrest</i> (B) DUE TO <i>CNS damage (subdural and/or subarachnoid bleed)</i> (C) DUE TO <i>Birth trauma & difficult delivery</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>7pm 6/13 1967</i> to <i>1230 am 6/15 1967</i> , that (I) (we) lost saw the deceased alive on <i>11pm 6/14 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J. A. Elliott</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/15/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>J. A. ELLIOTT</i>				23D. ADDRESS <i>Johns Hopkins Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>CREMATION</i>		24B. DATE <i>6-15-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>JOHNS HOPKINS HOSPITAL</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 19 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR		ADDRESS	

1230
C/M

6/12/67

2/12/67

With Volume 2 of the
US damage (and
Carboniferous

Mr

11/12/67 6/13 6/15 6/17

James
C

6/12/67
James Thompson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 5869

BIRTH NO. Pennsylvania 67 5869

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Patricia McBride

2. DATE AND HOUR OF DEATH

June 15, 1967 1 8⁴⁵ A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

42 Sinai Hospital of Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE B. COUNTY Maryland Baltimore Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Owings Mills 53-00

D. STREET ADDRESS (If rural, give location)

102 Oakmere Rd.

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married

8. DATE OF BIRTH

6/23/63

9. AGE (In years last birthday)

3

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

child

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Hugh McBride

14. MOTHER'S MAIDEN NAME

Josephine

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Hugh McBride 102 Oakmere Rd. Owings Mills, Md.

18. 756.21

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) ruptured esophageal varices

12 hrs

(B) biliary cirrhosis

3 years

(C) congenital biliary atresia

since birth

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

none

19A. DATE OF OPERATION

6/23/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

biliary atresia

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 6/14/67 19 to 6/15 19 67, that (1) (we) lost saw the deceased alive on 6/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Allan J. Montfried

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6/15/67

23C. PHYSICIAN'S NAME (Type)

Allan J. Montfried

M.D.

23D. ADDRESS

Sinai Hospital of Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

6/19/67

24C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

24D. LOCATION

(City, town, or county)

Baltimore Maryland.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

25B. NAME OF REGISTRAR

Robert E. Fisher

25C. FUNERAL DIRECTOR

H. J. Schlandt Owings Mills, Md.

ADDRESS

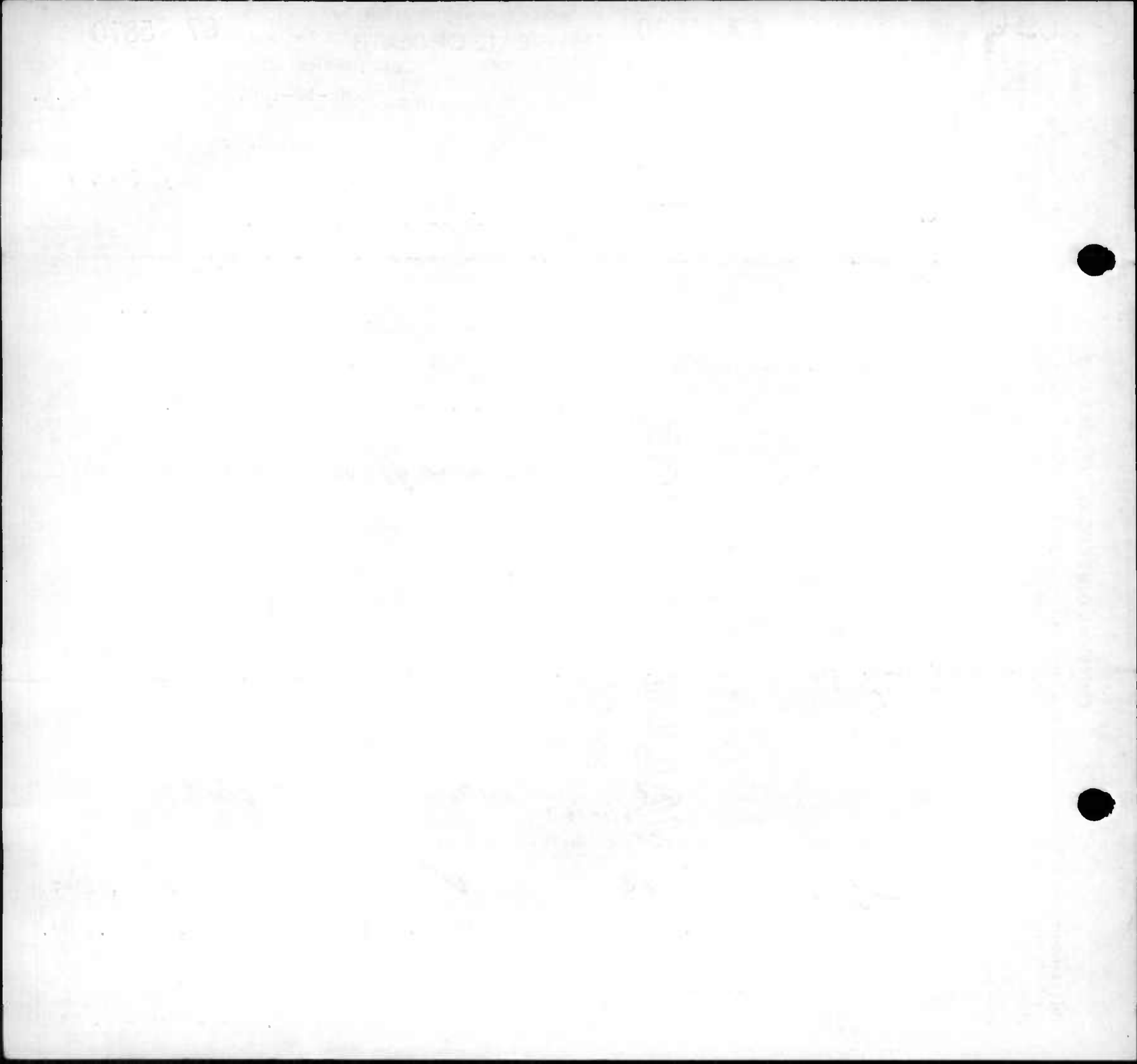
Hugh Mc Bride
105 Carman Rd.
Glenview, Ill. 60045

Barry J. Mc Bride
105 Carman Rd.
Glenview, Ill. 60045

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5870	
BIRTH NO. 67 5870		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILMER CLARKSON CARTER			
2. DATE AND HOUR OF DEATH		June-16-1967 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
at his residence		Maryland Baltimore City			
Ambassador Apts., 21218		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
06		Baltimore 12-01			
D. STREET ADDRESS (If rural, give location)		39th-Canterbury Road, 21218			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	White	Married	Feb-12-1892	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Insurance		Insurance		Baltimore	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Winfield Scott Carter		Annie Ruskell		U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no no		212-07-9296		C.R. Carter (son) 23 South St. City 21202	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) Carcinoma of Prostatic Gland		5 months	
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2/25/67		Ca Uterina		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/7/38 19 to 6/16/67 19, that (I) (we) last saw the deceased alive on 6/14/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis W. Gluck M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED June 16, 1967	
23C. PHYSICIAN'S NAME (Type) FRANCIS W. GLUCK M.D.				23D. ADDRESS 100 W. University Parkway, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
CREMATION		June-19-67		GREEN MOUNT	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 19 1967		Robert E. Farkas		Stewart & Mowen Co. 108-W-North-Av. 21201	



0-523

67 5871

BALTIMORE CITY HEALTH DEPARTMENT

67 5871

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SANFORD C. ONKST

2. DATE AND HOUR PRONOUNCED DEAD

June 16, 1967

4:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1511 South Charles Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

10/28/1912

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machinist Helper

10B. KIND OF BUSINESS OR INDUSTRY

Md. Drydock

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MARDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

1928-1940

16. SOCIAL
SECURITY NO.

218-14-5112

17. INFORMANT

ADDRESS

Mrs Charlotte Henry 25 Stabilizer Dr

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 17, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/20/67

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

(State)

5301 Frederick Ave Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

24B. NAME OF REGISTRAR

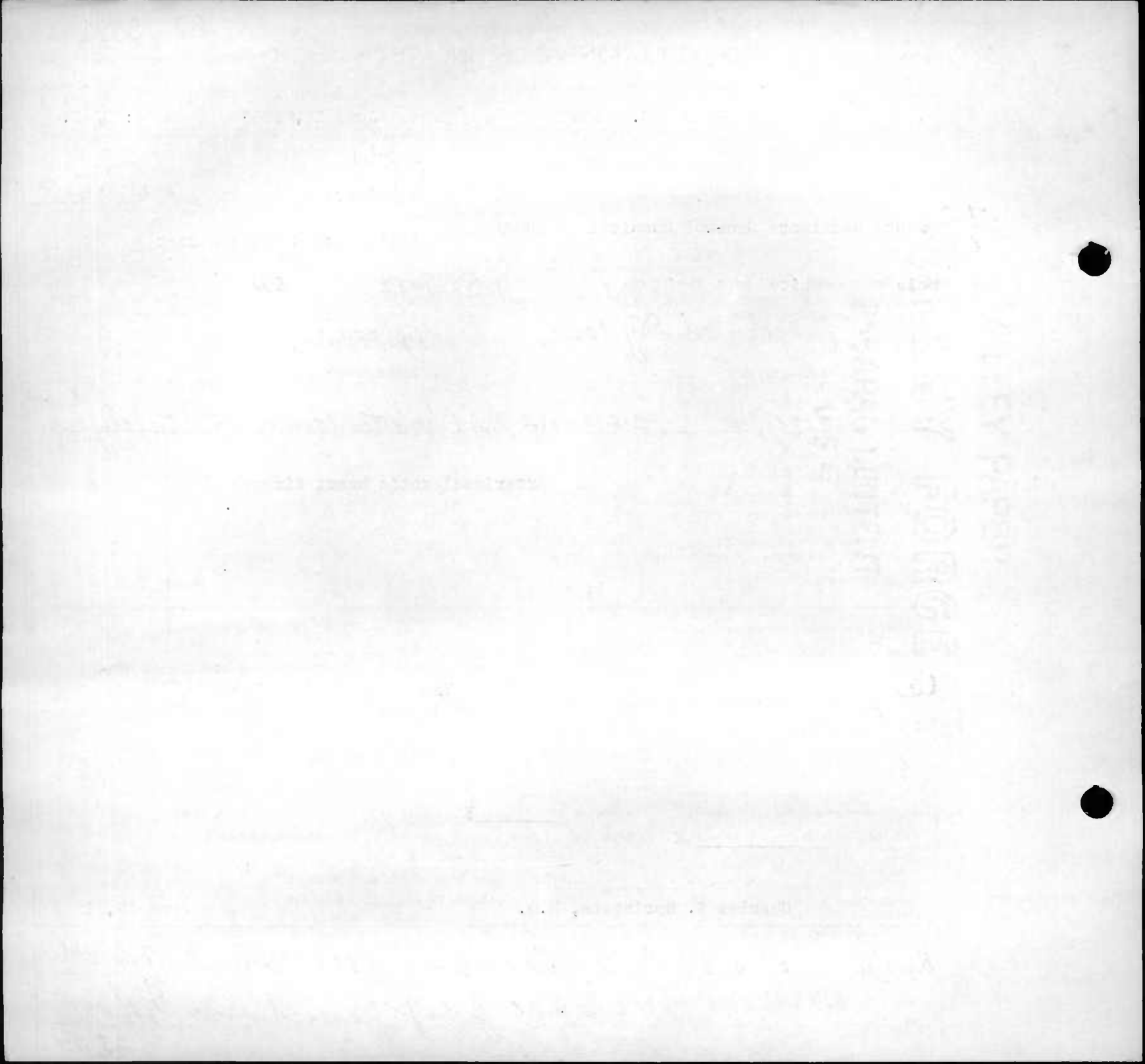
Robert E. Farkas

24C. FUNERAL DIRECTOR

John J. Cavanaugh Inc.

ADDRESS

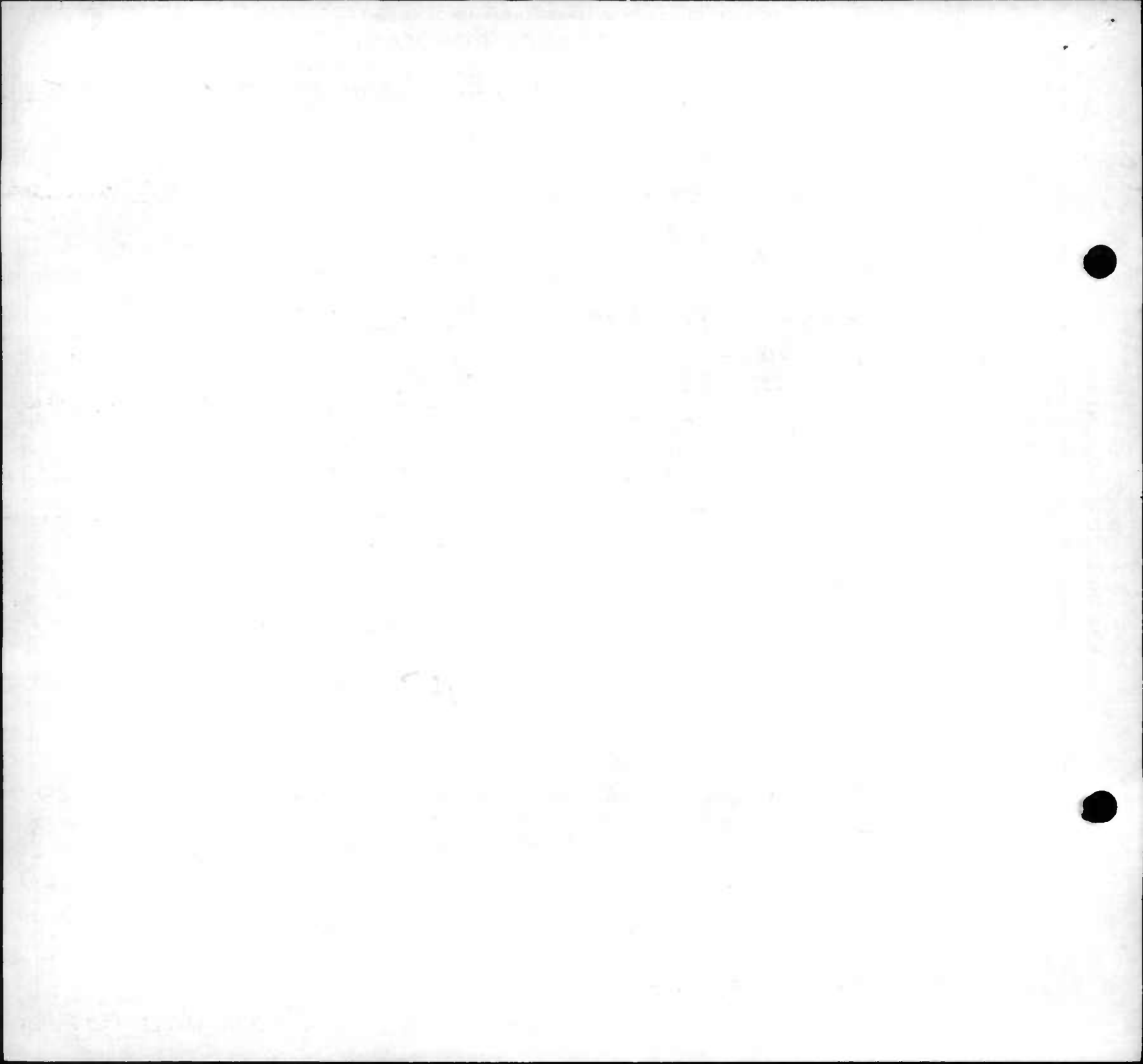
901 St. Hollins



FUNERAL DIRECTOR: IMPORTANT

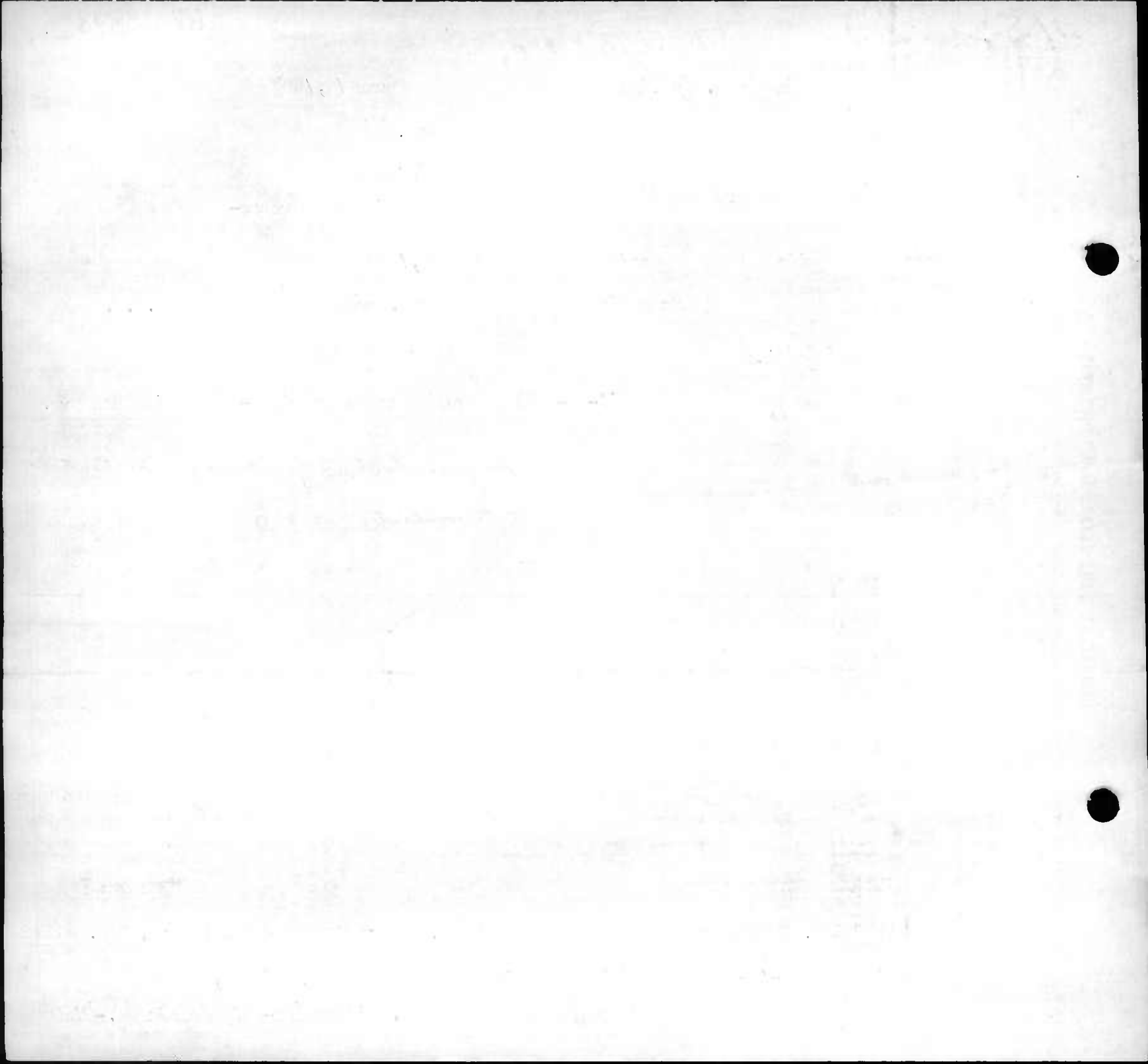
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
67 5872 CERTIFICATE OF DEATH											
Registered No. 67 5872											
BIRTH NO.											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print)		SEIDEL, LILLIAN, E.						2. DATE AND HOUR OF DEATH June 12, 1967 11:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland Baltimore						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL		D. STREET ADDRESS (If rural, give location) 1190 W. Belvedere Ave. #10						27-13			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 1-7-03		9. AGE (In years last birthday) 64		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Penna, Phila				12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME Isaac Bass				14. MOTHER'S MAIDEN NAME Jennie?							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Theodore A. Seidel - 1190 W. Belvedere Ave				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 4-20-11-203X		CAUSE OF DEATH (A) DUE TO ACUTE myocardial Infarction 4 days Congestive Heart Failure (B) DUE TO Arteriosclerotic cardio - 15 years Vascular Disease (C) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 1 year			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		MULTIPLE myeloma									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <input type="checkbox"/>							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 6-8 19 67 to 6-12 19 67, that (I) (we) last saw the deceased alive on 6-12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Francisco Sáenz M.D.								23B. DATE SIGNED 6-12-67			
23C. PHYSICIAN'S NAME (Type) Francisco Sáenz M.D.								23D. ADDRESS Sinai Hospital 24.0.			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE June 13/67		24C. NAME of CEMETERY or CREMATORY Roosevelt Mem. Park		24D. LOCATION Phila. Pa		(City, town, or county)		(State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sol Lerman		25D. ADDRESS 2nd - 6010 Reest. Road					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5873	
BIRTH NO. 67 5873				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Vaughn S. Collins</i>				June 13, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>48 Maryland General Hospital</i>				A. STATE <i>Maryland</i> B. COUNTY	
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
				D. STREET ADDRESS (If rural, give location) <i>5409 Hillburn Avenue</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>July 25, 1904</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Manager</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Acme Store</i>		11. BIRTHPLACE (State or foreign country) <i>Smyrna, Delaware</i>	
13. FATHER'S NAME <i>Leonard Collins</i>			14. MOTHER'S MAIDEN NAME <i>Florida Curlett</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>221-03-9874</i>		17. INFORMANT <i>Maud Burrows Collins - 5409 Hillburn Ave.</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Myocardial Infarct</i> DUE TO (B) <i>Arteriosclerosis CVD</i> DUE TO (C) <i>Previous Myocardial Infarct</i>	
				INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i> <i>10 year</i> <i>6 year</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>April</i> 1960 to <i>June 13</i> 1967, that (I) (we) last saw the deceased alive on <i>June 13</i> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W-H Townshend</i>				23B. DATE SIGNED <i>6/14/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Wilfred H. Townshend</i>				23D. ADDRESS <i>14 E. Eager Street - Baltimore, Md. 21202</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-16-67</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore National Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 19 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>John C. Miller Inc - 6415 Belair Rd. - 21206</i>	



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B. 620

67 5874

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5874

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) LEROY W. BROOKS, Sr.		2. DATE AND HOUR PRONOUNCED DEAD June 12, 1967 12:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 48 Maryland General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Cecil Co.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Perryville 57-00	
D. STREET ADDRESS (If rural, give location) General Delivery			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 7-23-24
9. AGE (In years last birthday) 42		10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. 10 19	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook Helper		10B. KIND OF BUSINESS OR INDUSTRY Mess Hall	
11. BIRTHPLACE (State or foreign country) Price Hill, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Henry Brooks		14. MOTHER'S MAIDEN NAME Stella Bobbit	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) yes W.W. II		16. SOCIAL SECURITY NO. 236-24-7125	
17. INFORMANT Mrs Emma J. Brooks		ADDRESS General delivery Perryville Maryland	

18. CAUSE OF DEATH E903.1		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebrocranial injuries		(A) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Found on East Monument St.			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) ? ? ?		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? Apparently fell			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED June 12, 1967			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/16/67	
23C. NAME OF CEMETERY or CREMATORY Balto. National Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		24B. NAME OF REGISTRAR Robert E. Taylor	
24C. FUNERAL DIRECTOR Edward E. Bueck		ADDRESS Hawesville, Md	

Will Bolt

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5875	
BIRTH NO. 67 5875		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CLAUDIA E. WOOLFORD		June 16, 1967 11:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Egdewood Nursing Home 6000 Bellona Ave		A. STATE Md B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-12 D. STREET ADDRESS (If rural, give location) 6000 Bellona Ave	
5. SEX Female	6. RACE Cau	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6/24/73	9. AGE (In years last birthday) 93	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Hooper		14. MOTHER'S MAIDEN NAME Bartlett	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 263 96 7311		17. INFORMANT ADDRESS Mr. Richard W. Woolford Ft. Pierce, Florida	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Myocardial infarction DUE TO (B) Generalized arteriosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 days 15+ yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes mellitus		18+ yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 13, 1967 to June 16, 1967, and that (I) (we) lost sight of the deceased on June 13, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick J. Vollmer		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-19-67	
23C. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER		23D. ADDRESS 6100 YORK RD, BALTIMORE, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/20/67		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION Baltimore, Md		24E. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. Baltimore, Md. 21202			
25A. DATE RECEIVED BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Sullivan		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. Baltimore, Md. 21202	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-1211

BALTIMORE CITY HEALTH DEPARTMENT

67 5876 CERTIFICATE OF DEATH

Registered No. 67 5876

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

George Novikoff

2. DATE AND HOUR OF DEATH

6/16/67 6:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

MD. BALTO

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTO

D. STREET ADDRESS (If rural, give location)

1730 Linden Ave.

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1/30/84

9. AGE (In years last birthday)

83

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

T

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

X

14. MOTHER'S MAIDEN NAME

X

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

16. SOCIAL SECURITY NO.

220-05-9327

17. INFORMANT

Chert

ADDRESS

18. 332X1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Broncho pneumonia
(A) ~~Anterior sclerotic heart disease~~
DUE TO due to

(B) Cerebrovascular accident.
(thrombosis)
DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Anterior sclerotic heart disease

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/2 1967 to 6/16 1967, that (I) (we) last saw the deceased alive on 6/16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Daniel C Wilkerson

M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6/16/67

23C. PHYSICIAN'S NAME (Type)

Daniel C Wilkerson

M.D.

23D. ADDRESS

421 Regester Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

June 20, 1967

24C. NAME OF CEMETERY or CREMATORY

PARSONS Cem.

24D. LOCATION

SALISBURY, MD.

(City, town, or county)

(State)

25A. DATE RECEIVED BY HEALTH DEPT.

JUN 19 1967

25B. NAME OF REGISTRAR

Robert E. Fickens

25C. FUNERAL DIRECTOR

Wm. Cook-BROOKS INC. 1217 ST. PAUL ST.

ADDRESS

George Westcott

2004

6/12/12

East Gate

Part

1730 River Ave

Trinity General Hospital

83

11/30/84

Trinity

in

in

Room

7

Room

X

X

Client

Brother's Home

Trinity General Hospital

Trinity General Hospital
(Trinity)

Trinity General Hospital

6/12/12

6/12/12

6/12/12

6/12/12

Trinity General Hospital

Trinity General Hospital

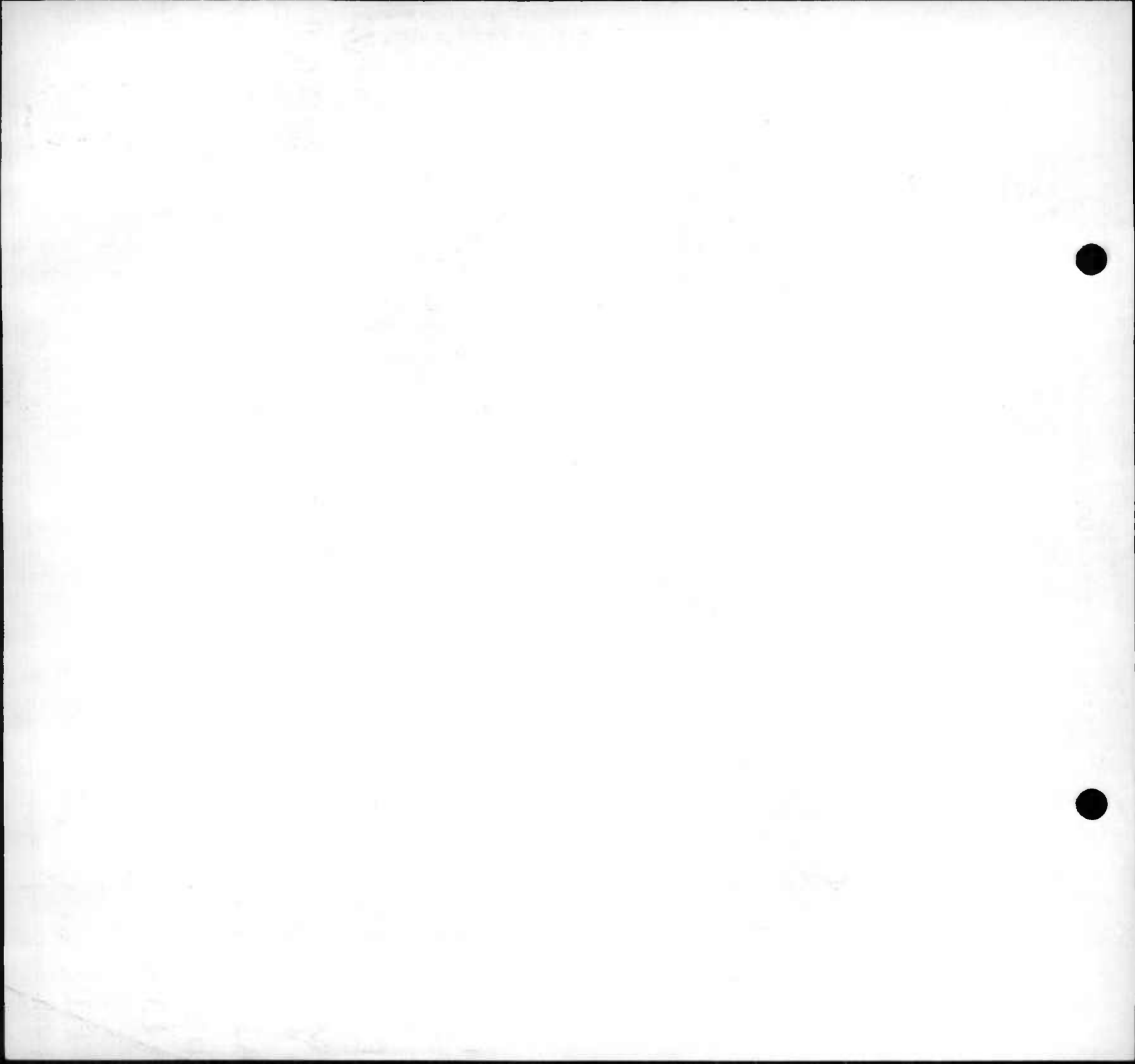
Trinity General Hospital

6/12/12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5877</u>	
BIRTH NO. <u>67 5877</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>CATHERINE CASEY</u>		2. DATE AND HOUR OF DEATH <u>6-18-67</u> <u>9:00 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>10-01</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>LITTLE SISTERS OF THE POOR</u> <u>90 1200 VALLEY STREET</u> <u>BALTIMORE, MARYLAND 21202</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>1200 VALLEY STREET</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u> DIVORCED (specify)	8. DATE OF BIRTH <u>7-2-1878</u>	9. AGE (In years last birthday) <u>88</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>	
13. FATHER'S NAME <u>SAMUEL TRADOR</u>		14. MOTHER'S MAIDEN NAME <u>HENRIETTA KEENAN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>145-28-8635A</u>		17. INFORMANT <u>LITTLE SISTERS OF THE POOR</u> ADDRESS <u>1200 VALLEY ST. BALTO., MD.</u>	
18. <u>422.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary edema</u> <u>Chronic A.S.C.U.D.</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>6.18</u> 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>6.18</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanley Ankudus</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6.19.67</u>	
23C. PHYSICIAN'S NAME (Type) <u>STANLEY ANKUDAS M.D.</u>		23D. ADDRESS <u>1101 MAIDEN CHOICE LANE, BALTO., MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>removal</u>		24B. DATE <u>6/18/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Granton West Vir.</u>	
24D. LOCATION (City, town, or county) (State) <u>Granton West Vir.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 19 1967</u>		25B. NAME OF REGISTRAR <u>Philip E. Faldus</u>	
		25C. FUNERAL DIRECTOR <u>Philip E. Faldus</u>		ADDRESS <u>2024</u>	



1
D-120

67 5878

BALTIMORE CITY HEALTH DEPARTMENT

67 5878

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM C. DAVIS

2. DATE AND HOUR PRONOUNCED DEAD

June 17, 1967 (Sat.) 8:55 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 21230

D. STREET ADDRESS (If rural, give location)

112 Warren Avenue

117 E. Fort Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

Sept 10 1890

9. AGE (in years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Ret Shipping Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Whol. Hardware

11. BIRTHPLACE (State or foreign country)

Washington Co, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Lewis C. Davis

14. MOTHER'S MAIDEN NAME

? Wachtell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217-09-3724

17. INFORMANT

Wm. S. Davis (Son) 117 E Fort Ave 21230

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

June 18, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

June 20 67

23C. NAME OF CEMETERY or CREMATORY

Holy Cross Cem.--Brooklyn A.A.Co., Md.

23D. LOCATION

(City, town, or county) (State)

CURTIS E. EVANS

24A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

24B. NAME OF REGISTRAR

Robert E. Farber, Jr.

24C. FUNERAL DIRECTOR

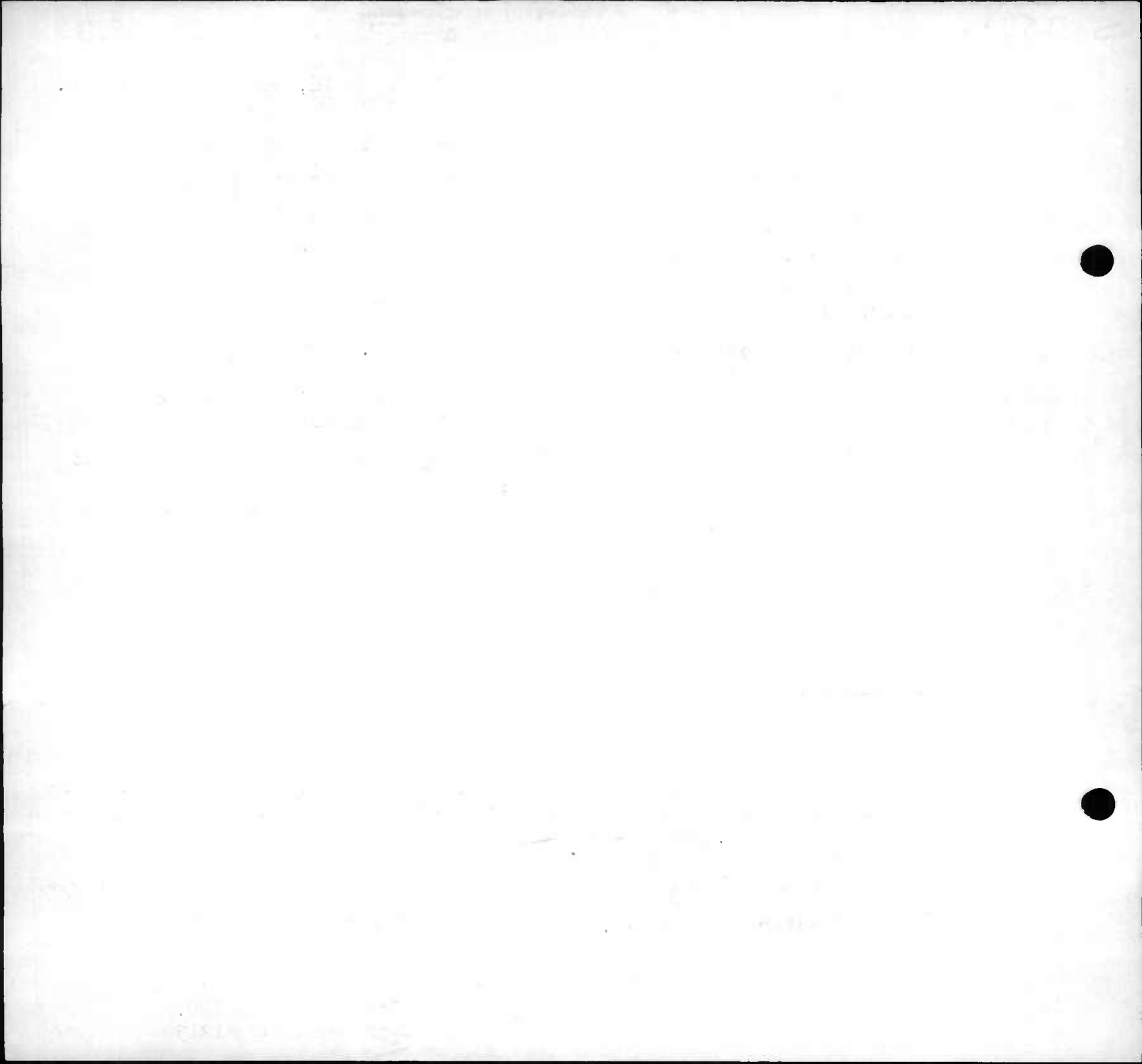
1400 S Charles St Balto Md 21230

WILLIAM GEORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5879	
BIRTH NO. 67 5879		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ADOLF JOHN STIEMKE		2. DATE AND HOUR OF DEATH JUNE 16, 1967 8:45 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3215 The Alameda				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY 9-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21218 D. STREET ADDRESS (If rural, give location) 3215 The Alameda			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Jan, 7, 1895	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Saint Paul Minnesota		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Zachary Gottlob Stiemke			14. MOTHER'S MAIDEN NAME Emma A. Rau				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214 36 9842		17. INFORMANT ADDRESS Mrs Adele Hoffmann Stiemke		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Myocardial infarction DUE TO (A) Coronary Atherosclerosis DUE TO (B) Symptomatic DUE TO (C) Immediate				CAUSE OF DEATH 3215 The Alameda INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 10 1956 to June 16 1967 , that (I) (we) last saw the deceased alive on June 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Lester A Wall Jr.				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 16 1967	
23C. PHYSICIAN'S NAME (Type) Lester A Wall Jr.				23D. ADDRESS 1039 Saint Paul Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/20/67		24C. NAME OF CEMETERY OR CREMATORY Oakhill Cemetery		24D. LOCATION (City, town, or county) (State) Watertown Wisconsin	
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS INC. BALTIMORE MARYLAND 21213			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5880		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 5880	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) ANNA LAURENE BOHNLOFINK				6-15-67 3:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY Baltimore	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - 21210 27-13			
				D. STREET ADDRESS (If rural, give location) 1190 W. Belvedere Ave. Apt #202			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2-14-92	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Frederick K. Suehle			14. MOTHER'S MAIDEN NAME Anna G. Myers				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-46-8732		17. INFORMANT Miss Edna Suehle (sister)		ADDRESS Apt. 202, Belvedere Towers, 21210
18. 4201 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH ? 60 hr	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Rupture of left ventricle secondary to acute myocardial infarction			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) in, New York			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/12 19 67 to 6/15 19 67 , that (I) (we) last saw the deceased alive on 6/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John R. Vaughn, Jr.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/15/67	
23C. PHYSICIAN'S NAME (Type) JOHN R. VAUGHN, JR.,				23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Entombment June 19, 1967		Lorraine Park Mausoleum, Baltimore Md.		Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.		ADDRESS Baltimore Md.	

Frank White, Windsor

Frederick K. Zuehlke

2-11-72

Maple Point, N.S.

Robert White

Windsor, N.S.

Mr. White

1
H-325

67 5881

BALTIMORE CITY HEALTH DEPARTMENT

67 5881

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DAVID J. HUDSON

2. DATE AND HOUR PRONOUNCED DEAD

June 17, 1967 12:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Pier 1-A, Bethlehem Steel

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2113 West Vine Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

DEC-11-1934

9. AGE (In years last birthday)

32.30

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

REGAR

10B. KIND OF BUSINESS OR INDUSTRY

SHIPBUILDING

11. BIRTHPLACE (State or foreign country)

FREDRICKSBURG VA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Honny Hudson

14. MOTHER'S MAIDEN NAME

MARTHA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

YES

KOREAN

16. SOCIAL SECURITY NO.

227-40-9876

17. INFORMANT

ADDRESS

MOZELLE HUDSON 2113 VINE ST

18. EY 29.81 + 322.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO Drowning

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Acute ethylism

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

water

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Bethlehem Steel Pier 1-A, Key Highway

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) (Min.)
6-16-67 11:30 P.

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

Fell off pier

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 17, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

6/22/67

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION (City, town, or county) (State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Marshall P. Hays 68 N. Gilmorton

ADDRESS

N 990X 670005891

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Your obedient servant,

J. H. [Signature]

[Faint text]

[Faint text]

[Faint text]

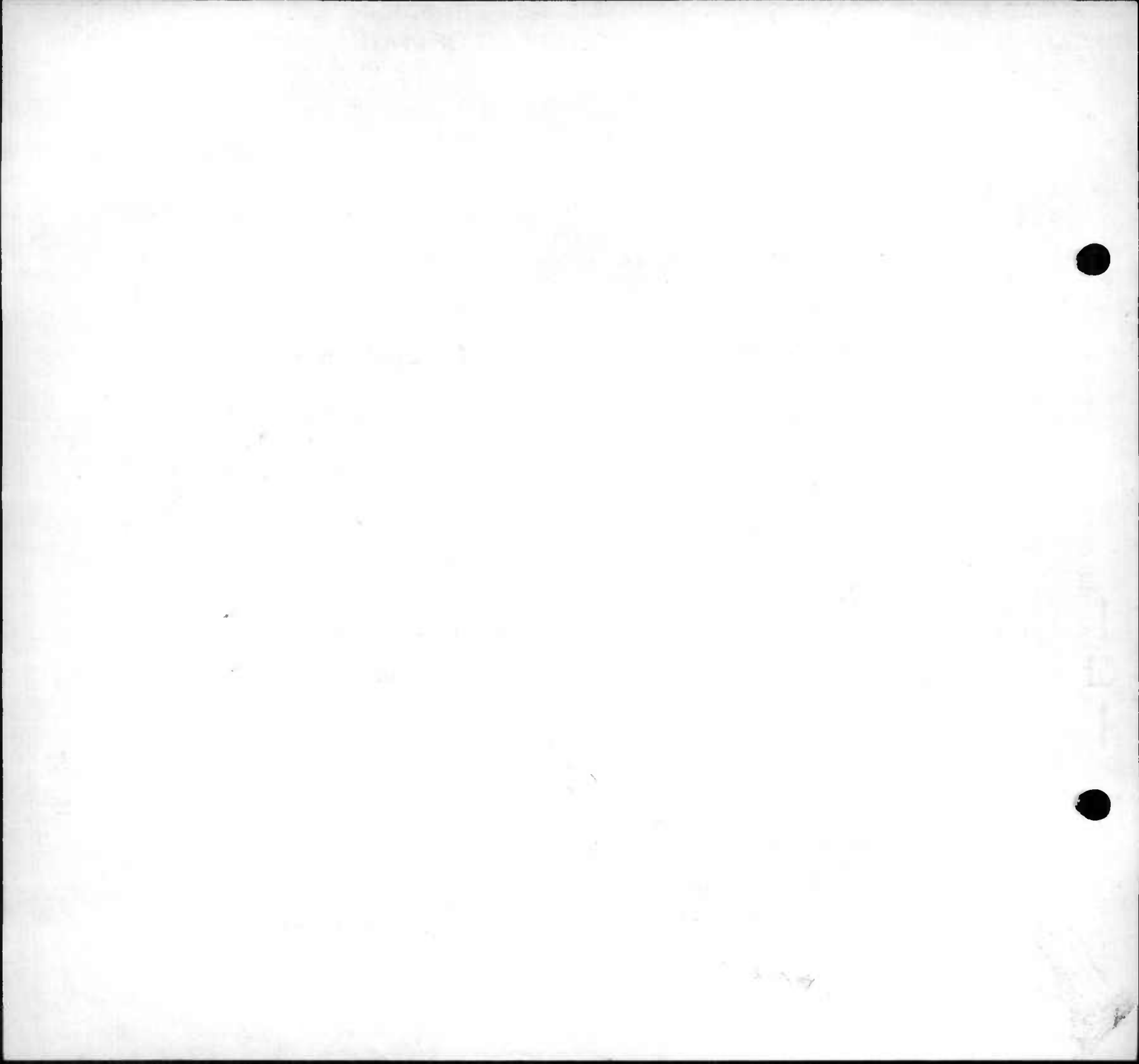
[Faint text]

[Faint text]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5882				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5882	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) JACQUELINE W. WHE				2. DATE AND HOUR OF DEATH 6.17.67. 2A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 27-10	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 4714 ALHAMBRA AVE. #12			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 5/8/63	9. AGE (In years last birthday) 4	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME HOWARD W. WHE				14. MOTHER'S MAIDEN NAME EVELYN WILLIAMS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Evelyn W. WHE		ADDRESS 4714 Alhambra Ave	
18. 493X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) GASTRO INTESTINAL BLEED (B) PNEUMONIA (C) 2 DAYS 2 DAYS				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CEREBRAL PALSY							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) ?		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from 6.14.1967 to 6.17.67 19 67 , that (I) (we) last saw the deceased alive on 6.17.1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE K. Shaw				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/17/67	
23C. PHYSICIAN'S NAME (Type) K. SHAW				23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-20-67		24C. NAME OF CEMETERY or CREMATORY Pleasant Rest Cem. Balto.		24D. LOCATION (City, town, or county) (State) Id.	
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Harold O. Dyett F.H.		ADDRESS 1701 Laurens St.	



1
M 252

67 5883

BALTIMORE CITY HEALTH DEPARTMENT

67 5883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

DELIA

MC KNIGHT

2. DATE AND HOUR PRONOUNCED DEAD

June 15, 1967

10:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3314 Edmondson Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
South Carolina

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Sumpter

D. STREET ADDRESS (If rural, give location)

Route 3

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

August 30, 1895

72

9. AGE (In years
last birthday)

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Sumpter, S. Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Elmira Mc Kane

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

17. INFORMANT

Ida Wright

ADDRESS

3314 Edmondson Ave. Balto. Md #29

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

6/16/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-19-67

23C. NAME OF CEMETERY or CREMATORY

Bell Mill Cemetery

23D. LOCATION

(City, town, or county)

(State)

Sumpter, S. Carolina

24A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

MORTON & DYETT FUNERAL HOME

ADDRESS

1701 Laurens St. Balto. Md.

EV. JOURNAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5884</u>	
BIRTH NO. <u>67 5884</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DORIS ROBINSON (May)		6-15-67 1:25 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33			A. STATE MARYLAND		
			B. COUNTY BALTIMORE		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 3846 OAKFORD AVE		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 1-26 38	9. AGE (In years last birthday) 29	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse Aide		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S. A.		13. FATHER'S NAME THOMAS ROBINSON		14. MOTHER'S MAIDEN NAME LOUISE HARVEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Louise Robinson 3846 Oakford Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO Systemic Sclerosis (B) DUE TO (C) DUE TO		
19. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hemolytic anemia		
20A. AUTOPSY? (Yes or No) yes			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/29 19 67 to 6/15 19 67, that (I) (we) last saw the deceased alive on 6/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harmon J Eyre				23B. DATE SIGNED 6/15/67	
23C. PHYSICIAN'S NAME (Type) Harmon J Eyre				23D. ADDRESS 601 N Broadway Balt Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-19-67		24C. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.	
24D. LOCATION Balt.		24E. ADDRESS Md.		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Marguerite Dyett F.H.	
				1701 Laurens St.	

1954

Thyroidectomy

Thyroidectomy
Yes No

6/12 6/12 6/12

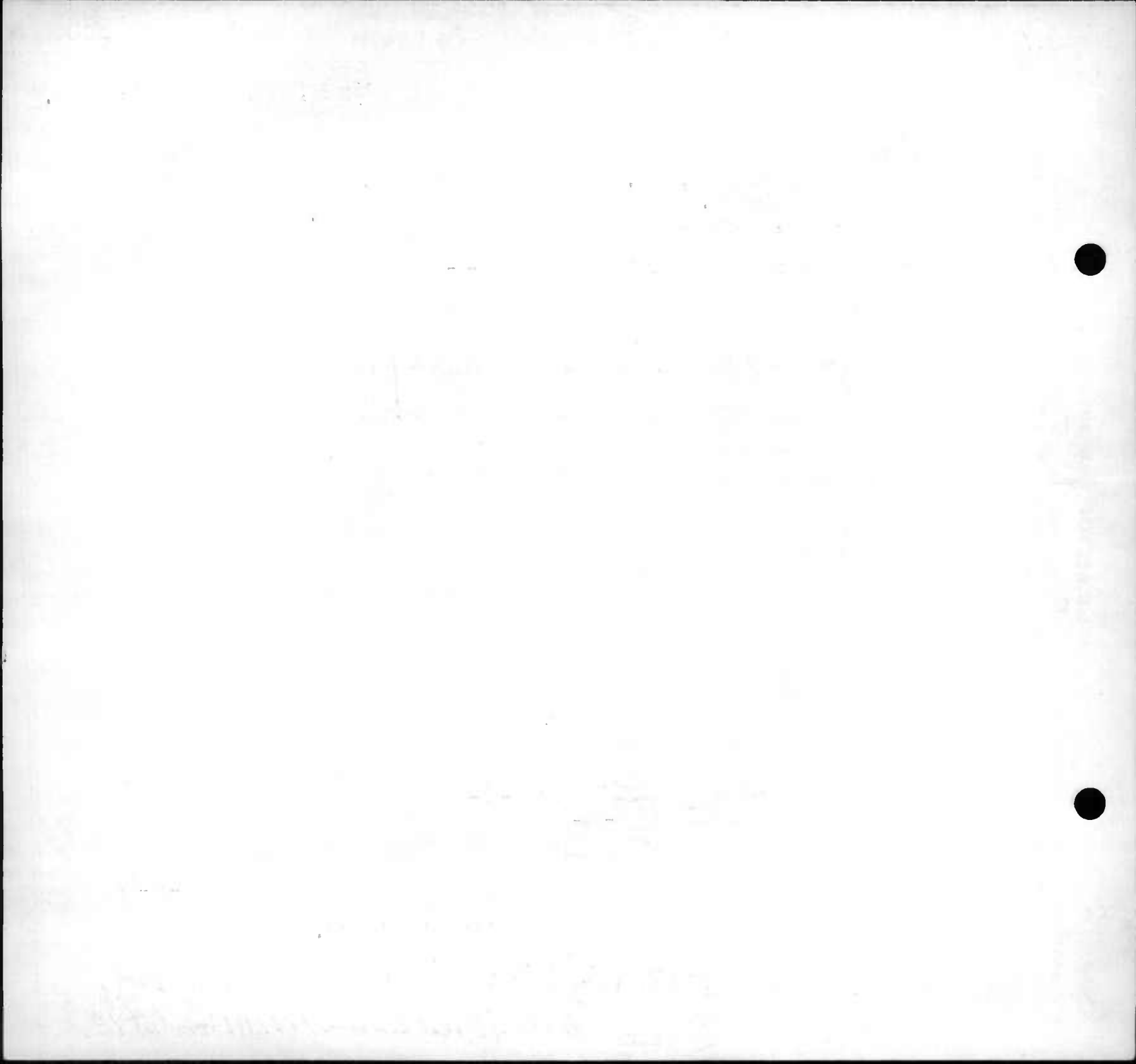
6/12
101 in breast
part of

Thyroidectomy
Hormone I Five

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5885	
BIRTH NO. 67 5885		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Margaret Smallwood		2. DATE AND HOUR OF DEATH May 30, 1967 1:50 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 14-03		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital, Inv. 1514 Division St. Baltimore, Maryland		D. STREET ADDRESS (If rural, give location) 533 Roberts St.			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-2-20	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: If Under 24 Hrs. Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James W. Simms		14. MOTHER'S MAIDEN NAME Mary M. Chaney	
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown. If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 2121883630		17. INFORMANT Family	
18. 3-01-X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Swelling of left hemisphere (B) Fatty change liver (C) Bronchitis		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-14-67 19 to 19, that (I) (we) last saw the deceased alive on 5-30-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-30-67	
23C. PHYSICIAN'S NAME (Type) A MINI		23D. ADDRESS M.D. 1514 Division St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 2/67		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Md.	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Robert E. Taylor	
				ADDRESS 1014 Bond St. 13,	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N. 6201

67 5886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 5886

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Mr John A. Norris		June 18, 1967 1:50 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital				A. STATE Md			
				B. COUNTY 907			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1508 Gorsuch Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days	
Male	Caucasian	Widower		Dec 12, 1894	72		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Painter				Painter		England	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
Unknown John B. Norris				U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				216-184999		Mrs William Dixon	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
331X I				Cerebro Vascular Accident			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from 6/17 1967 to 6/18 1967, that (1) (we) last saw the deceased alive on 6/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Nat E. Watson Jr						6/18/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DR NAT E. WATSON				M.D. THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6-21-67		Baltimore		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
JUN 19 1967		Robert E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd.			

June 10, 1942

Union Memorial Hospital
1200 Greenwich Ave
The 12, 1942
England
Unknown

Mr. William Dean
Carter (Vascular Accident)

1/c

Not a duplicate
6/10/42
6/10/42
6/10/42

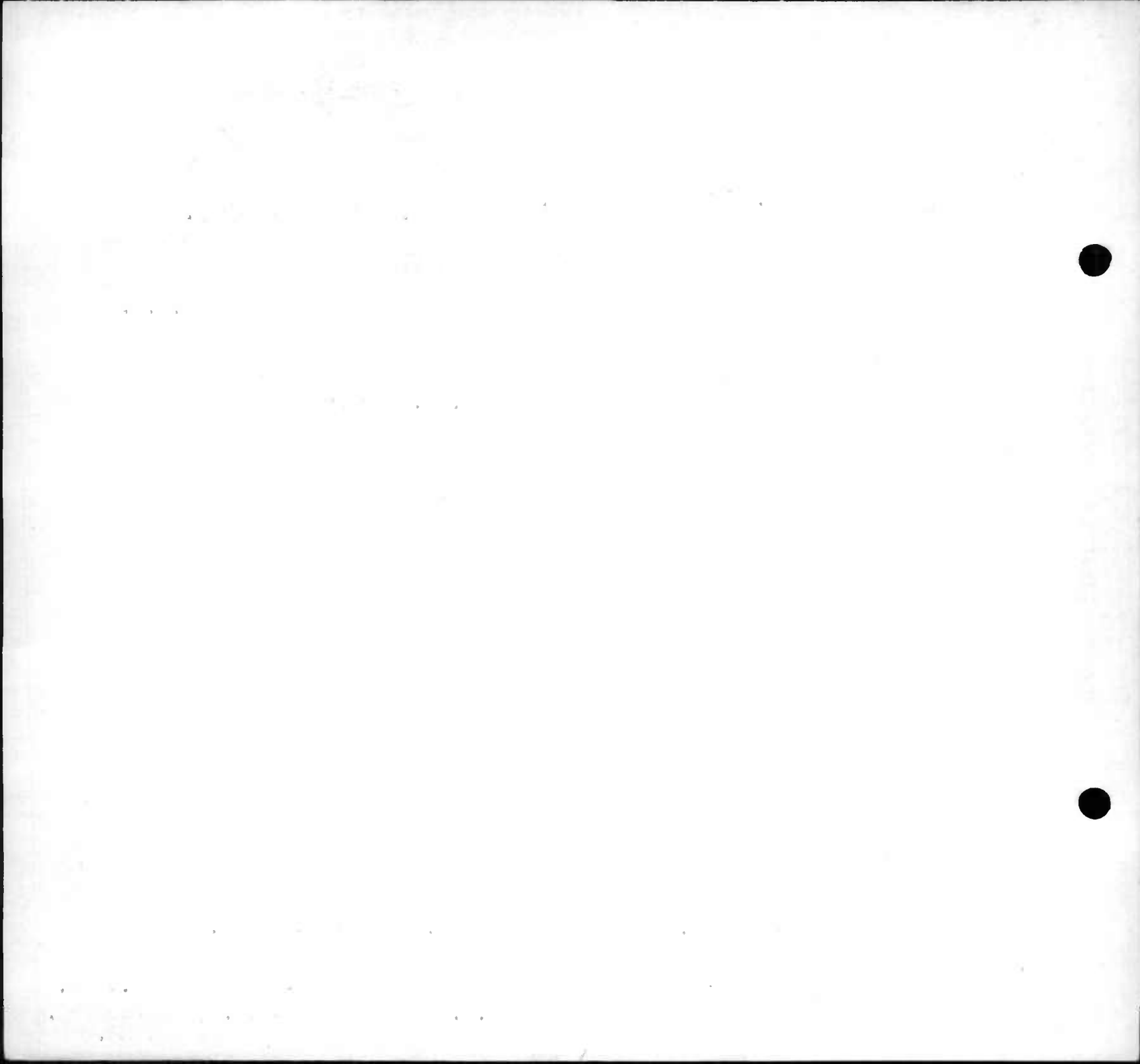
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100-11111

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 5887	
CERTIFICATE OF DEATH				Registered No. 67 5887	
BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mary Howard Lloyd		June 16, 1967 1 45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
00 100 W. University Pkwy.			Maryland 12 01		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			100 W. University Pkwy.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH 9/2/1877	9. AGE (In years last birthday) 89
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker		Own Home		Maryland	
13. FATHER'S NAME Edward Lloyd				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				14. MOTHER'S MAIDEN NAME Mary Howard	
16. SOCIAL SECURITY NO.				17. INFORMANT 308 Northwind Road Dr. R. Carmichael Tilghman 21204	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>arteriosclerotic cardiovascular disease</i> DUE TO <i>disease</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/25/67 19 to 6/16/67 19, that (I) (we) last saw the deceased alive on 6/14/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis W. Gluck				23B. DATE SIGNED 6/16/67	
23C. PHYSICIAN'S NAME (Type) Francis W. Gluck				23D. ADDRESS M.D. 100 W. University Pkwy.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/19/1967		24C. NAME OF CEMETERY or CREMATORY Wye House	
				24D. LOCATION (City, town, or county) (State) Easton, Talbott Cty., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5888					REGISTERED NO. 67 5888		CITY OF BALTIMORE		
BIRTH NO. 67 5888					DATE AND HOUR OF DEATH 6-17-67 2:10 A.M.				
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Sister Mary Laurence Saunderson					2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 9-01				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3725 Ellerslie Ave.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3725 Ellerslie Ave.				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 2-11-1880	9. AGE (In years last birthday) 87	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Albert Saunderson					14. MOTHER'S MAIDEN NAME Elizabeth Turner				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. -				
17. INFORMANT Mother Mary Alexander					ADDRESS Above				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH ASCVD with myocardial Ischemia				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH 3 years				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Carcinoma (basal cell) face 14 years				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (the hospital) attended the deceased from May 19 60 to June 19 67, that (I) (we) last saw the deceased alive on June 15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Com. H. Kammer					23B. DATE SIGNED 6/19/67				
23C. PHYSICIAN'S NAME (Type) William H. Kammer					23D. ADDRESS 6011 York Rd., Balto., Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-20-67		24C. NAME OF CEMETERY or CREMATORY St. Elizabeths Convent		24D. LOCATION (City, town, or county) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd.					

4-20-1900

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1000 1000

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5889	
BIRTH NO. 67 5889		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Minnie M. Briddell			
2. DATE AND HOUR OF DEATH June 15, 1967 10:30 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 13-07 D. STREET ADDRESS (If rural, give location) Wyman Park Apts.			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green N. H.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 9-7-1893	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hostess		10B. KIND OF BUSINESS OR INDUSTRY Apartment Bldg.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William Mcgee		14. MOTHER'S MAIDEN NAME Minnie Reppert			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-4131		17. INFORMANT ADDRESS Elsie M. Warner Balto., Md.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Coronary thrombosis		CAUSE OF DEATH (A) Coronary thrombosis DUE TO (B) Atherosclerosis in heart & arteries DUE TO (C) Generalized atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 hr. 1 yr. 5 yr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1 19 67 to June 15 19 67 , that (I) (we) last saw the deceased alive on June 1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE Norman R. Freeman Jr.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/16/67	
23C. PHYSICIAN'S NAME (Type) Norman R. Freeman Jr.		23D. ADDRESS 11w. 29th St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-17-67		24C. NAME of CEMETERY or CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.	

125

87 2380

87 2380

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5880					67 5880				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Myrtle A. Helms					2. DATE AND HOUR OF DEATH 6-17-67 9:00 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Long Green N. H.					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 12-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3333 N. Charles St.				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 7-19-1895	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY Social Security		11. BIRTHPLACE (State or foreign country) N. C.			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph C. Helms					14. MOTHER'S MAIDEN NAME Vashti L. Belk				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219-42-5726		17. INFORMANT Bessie Helms				ADDRESS Above
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO (B) ASCVD DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 3 mo 7	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 19 67 to June 18 19 67 , that (I) (we) last saw the deceased alive on June 16 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Newland E. Day					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED June 18, 1967	
23C. PHYSICIAN'S NAME (Type) Newland E. Day					23D. ADDRESS M.D. 4 E. 33rd St., Balto., Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-21-67		24C. NAME OF CEMETERY or CREMATORY Monroe City			24D. LOCATION (City, town, or county) (State) Monroe N.C.		
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967			25B. NAME OF REGISTRAR Robert E. Farber			25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd.			

Leah's Memory

1924

June 17

June 18

June 19

Memorandum 2. Day

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

67 5891 CERTIFICATE OF DEATH

Registered No. 67 5891

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Mary Anderson

2. DATE AND HOUR OF DEATH

June 17, 1967

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

90 Edgewood Nursing Home
6000 Bellona Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3701 Loch Raven Blvd.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

11-19-1874

9. AGE (In years
lost birthday)

92

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Melville, N.J.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Edward Thompson

14. MOTHER'S MAIDEN NAME

Rachel -

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

212-10-8306

17. INFORMANT

Wilbur S. Duvall same

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 13 1967 to Jan 17 1967,
that (I) (we) last saw the deceased alive on Jan 13 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Frederick J. Vollmer

M.D.

Attending
Phys.

Med.
Director

Staff
Phys.

23B. DATE SIGNED

6-17-67

23C. PHYSICIAN'S
NAME (Type)

6100 York Rd

M.D.

23D. ADDRESS

FREDERICK J VOLLMER

24A. BURIAL CREMATION, REMOVAL (specify)

Burial

24B. DATE

6/19/67

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cem.

24D. LOCATION

Balto. Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

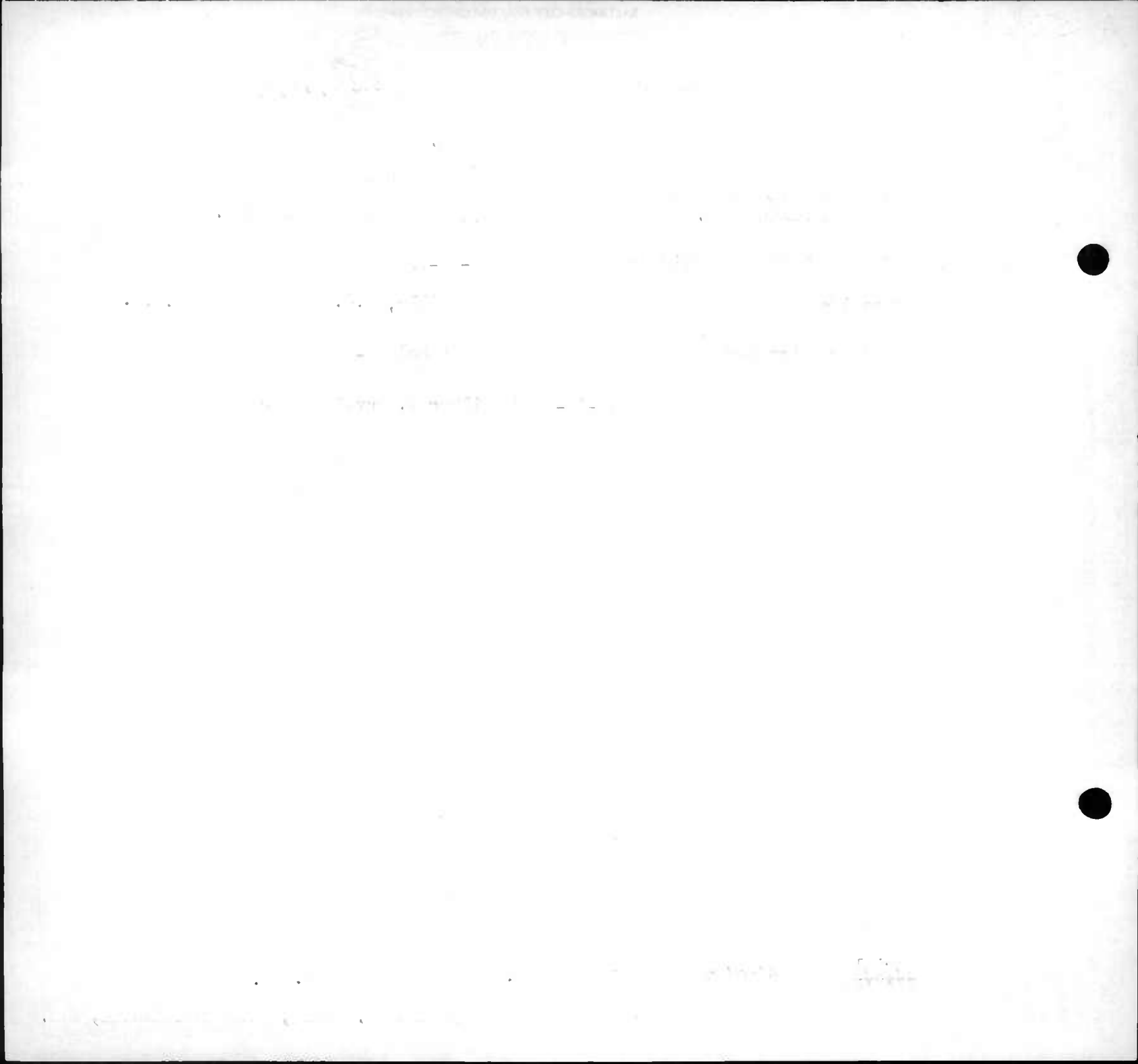
25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc Baltimore, Md.

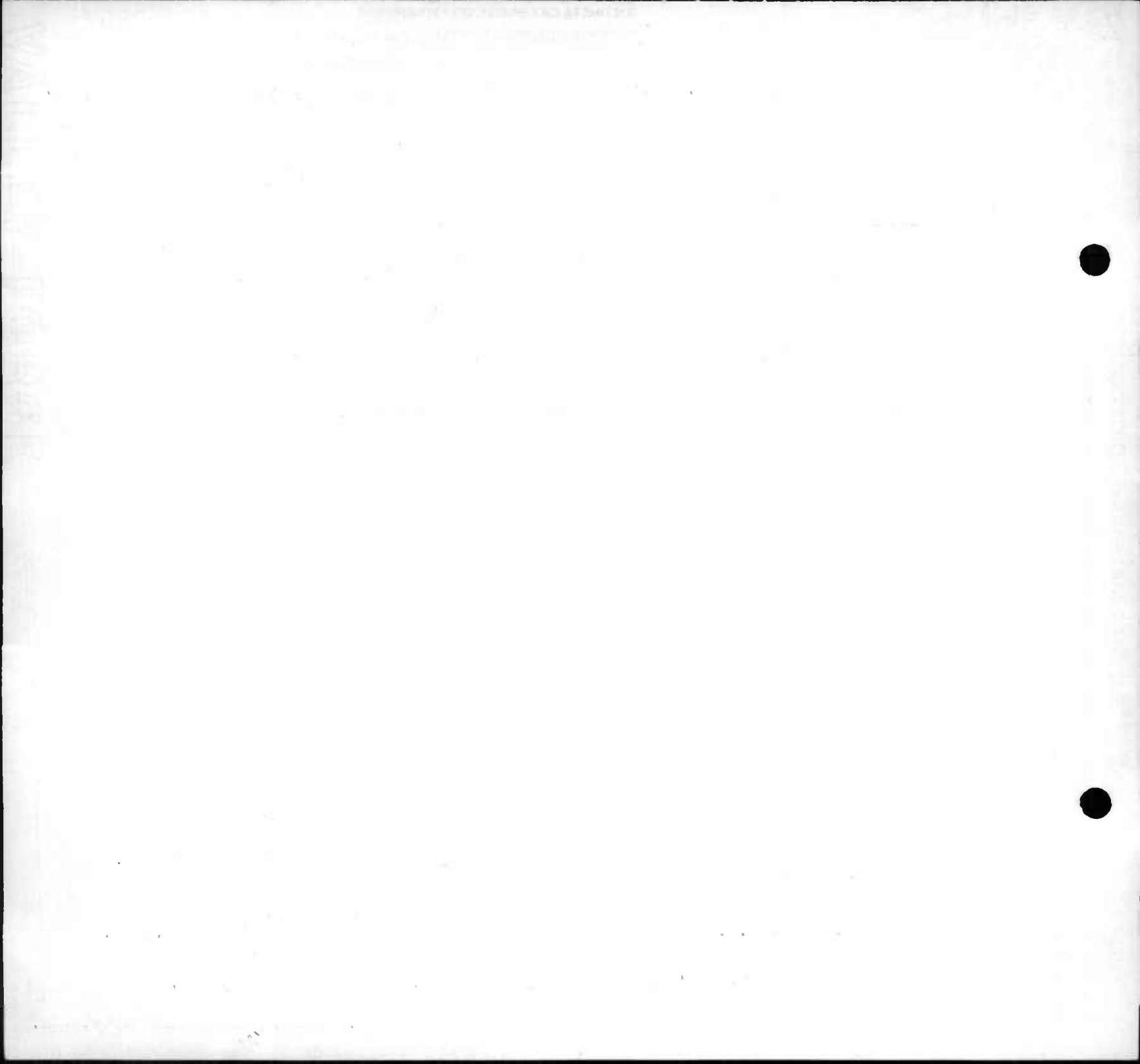
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

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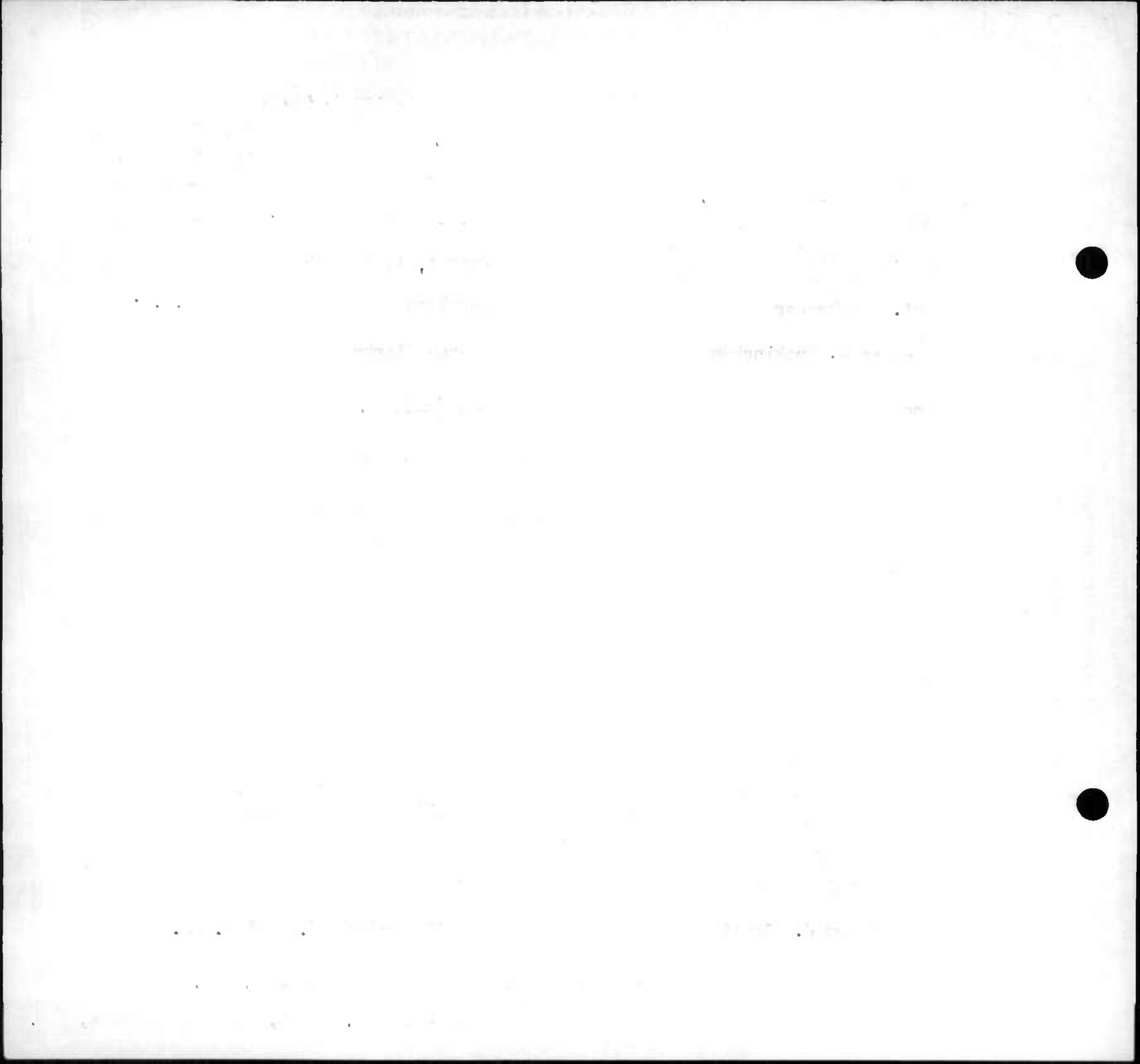
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5892	
BIRTH NO. 67 5892		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Ellen M. Hart		2. DATE AND HOUR OF DEATH June 16, 1967 9 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 945 Rodmanway		A. STATE Md. B. COUNTY 26-34			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21205			
		D. STREET ADDRESS (If rural, give location) 945 Rodmanway			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH July 20, 1888	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Brown			14. MOTHER'S MAIDEN NAME Josephine Suter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Elmer Hart 7141 Eastbrook Ave	
18. 420.1 I		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) Acute Coronary Occlusion DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hypertensive Heart Disease DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in at about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1965 to June 19 67 , that (I) (we) last saw the deceased alive on 19 and that (a) (my) last opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE John G. Orth, M.D.				23B. DATE SIGNED 6/16/67	
23C. PHYSICIAN'S NAME (Type) JOHN G. ORTH, M.D.				23D. ADDRESS 8019 Philadelphia Road Balto., Md. 21206	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 6/19/67		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

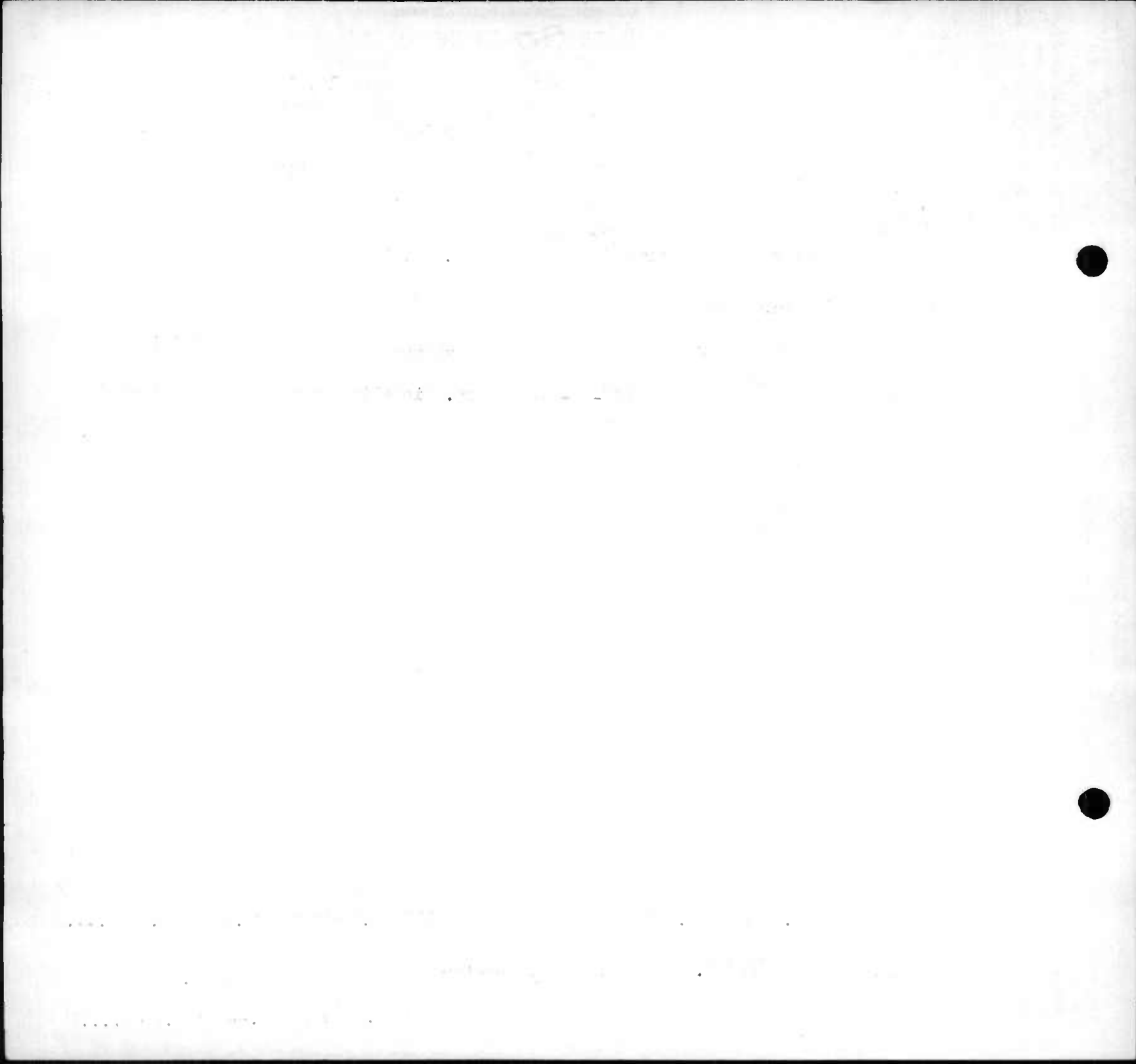
BALTIMORE CITY HEALTH DEPARTMENT				67 5893		Registered No. 67 5893	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Anne Buckingham		June 17, 1967 3:15 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
002915 Markley Ave.				Md. 27-02			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				2915 Markley Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
female	white	single	July 1, 1881	85			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ret. Bookkeeper				Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James R. Buckingham				Anne Clarke			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no				Mrs John V. Sperlein		same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X1				Cerebral Hemorrhage		5 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) arteriosclerotic cardiovascular disease with hypertension		20 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 2, 1948 to June 17, 1967, that (I) (we) last saw the deceased alive on June 17, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Edward J. Alessi						6/17/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Edward J. Alessi				6217 Harford Rd. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
burial		6/19/67		New Cathedral Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 19 1967		Robert E. Taylor, M.D.		Leonard J. Ruck, Inc		Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5894	
BIRTH NO. 67 5894		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOSEPH SANTORA		2. DATE AND HOUR OF DEATH June 19, 1967 4 A . M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2814 White Avenue		A. STATE Maryland B. COUNTY 27-06			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21214			
		D. STREET ADDRESS (If rural, give location) 2814 White Ave.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Feb. 14, 1891	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cement finisher:retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Pete Santora		14. MOTHER'S MAIDEN NAME unknown ? Saracicini	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-07-9124		17. INFORMANT Mrs. Michelina Santora	
				ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 163X I		CAUSE OF DEATH (A) Paraneoplasia of Lungs DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 yr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Arterio-sclerotic Cardio-Vascular Disease		?	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1940 to June 19 1967 , that (I) (we) last saw the deceased alive on June 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Joseph S. Blum		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/19/67	
23C. PHYSICIAN'S NAME (Type) Dr. Joseph S. Blum		M.D.		23D. ADDRESS 1115 N. Calvert St., Balto., Md....2	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 6/22/67.		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.--Balto., Md....14		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5895
BIRTH NO. 67 5895		CERTIFICATE OF DEATH		
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 6/17/67 10⁴⁵ a.m.		
1. NAME OF DECEASED (Type or Print) CARBALLEDO, MANUEL				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33		A. STATE MARYLAND B. COUNTY Balt. Co.		
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5752 UTRECHT ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-20-94	9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Spain
12. CITIZEN OF WHAT COUNTRY? Cuba				
13. FATHER'S NAME MANUEL & Carballedo		14. MOTHER'S MAIDEN NAME Josefa Arias		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Jesus Gonzalez ADDRESS (Same)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma of Prostate		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH at least 1 year.
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION 6/14/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Clinical Stage 4		20A. AUTOPSY? (Yes or No) Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from JUNE 7, 1967 to JUNE 17, 1967 , that (I) (we) last saw the deceased alive on JUNE 17, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Herbert Schwarz		23B. DATE SIGNED JUNE 17, 1967		
23C. PHYSICIAN'S NAME (Type) HERBERT SCHWARZ		23D. ADDRESS JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/21/67		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery
24D. LOCATION Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. JUN 19 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214

6/17/62

WATKINS

6/17/62

Mr. J. H. Watkins
of
Watkins

6/17/62 (Handwritten)

June 17, 1962

June 17, 1962

X

Handwritten signature

G. 655

67

5896

BALTIMORE CITY HEALTH DEPARTMENT

67

5896

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH GORMAN

2. DATE AND HOUR PRONOUNCED DEAD

6-13-67

11:25 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

928 WILMOST COURT

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

928 Wilmost Court 21202

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)~~Married~~ widowed

8. DATE OF BIRTH

July 10, 1890

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

ret. Plumber

10B. KIND OF BUSINESS OR INDUSTRY

Plumbing

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John A. Gorman

14. MOTHER'S MAIDEN NAME

Bertha J. Sommer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W.W. 1

16. SOCIAL
SECURITY NO.

220-07-5100

17. INFORMANT

ADDRESS

James F. Gorman 2916 Louise Ave. Balto., Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic
DUE TO
XXXXX

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) cardiovascular disease
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

6-13-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/16/67

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

Balto., Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto., Md.

ADDRESS

WFO 72

July 10, 1950

Attn: Mr. [illegible]

Dear Sir:

Enclosed

are [illegible]

for your information

John L. [illegible]

250-07-0100 [illegible] [illegible] [illegible]

V.M. [illegible]

[illegible]

[illegible]

WFO

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

B-620

67 5897

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5897

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH E. BURKE

2. DATE AND HOUR PRONOUNCED DEAD

June 16, 1967 1:43 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

35 Church Home Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

434 S. Bond Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

Dec. 30, 1926.

9. AGE (In years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Plumbers Helper

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John M. Burke

14. MOTHER'S MAIDEN NAME

Anne King

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). If yes, give war or dates of service)

Yes

WW 2

16. SOCIAL
SECURITY NO.

Unk.

17. INFORMANT

ADDRESS

Mrs. Anne Burke, 9003 Briar Rd. Balto. Md. 21234

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty Alteration of Liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/16/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/19/67.

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 19 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

RECEIVED

NOV 10 1964

10/10/64

10/10/64

10/10/64

10/10/64

W. 452

67 5898

BALTIMORE CITY HEALTH DEPARTMENT

67 5898

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ALBERT WILLIAMS, JR.

2. DATE AND HOUR PRONOUNCED DEAD

June 16, 1967

8:30 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1028 North Broadway

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Oct. 2, 1950

9. AGE (In years
last birthday)

16

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Bald. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Albert Williams Sr.

14. MOTHER'S MAIDEN NAME

Helene Porter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Albert Williams Jr.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Multiple stabwounds of trunk
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

sidewalk

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

In front of 2002 E. LaFayette Ave.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
6-16-67 7:30 P.

21E. INJURY OCCURRED

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 17, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 18 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Milton E. Elickson 11297 Cedar

ADDRESS

Oct 2, 1950
Field, Mr.
Helen Foster
Robert Williams

Mr.
Robert Williams
at home
Kings

Robert Williams
Helen Foster
Field, Mr.

W 326

67 5899

BALTIMORE CITY HEALTH DEPARTMENT

67 5899

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____									
1. NAME OF DECEASED (Type or Print) ELIZABETH (Lizzie)					2. DATE AND HOUR PRONOUNCED DEAD June 15, 1967 9:40 P. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 418 E. 20th Street					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 418 E. 20th Street				
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH July 4, 1915	9. AGE (In years last birthday) 51	11. Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Daniel Reed			14. MOTHER'S MAIDEN NAME Lydia Harrington						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Ernest Witcher 418 E 20th St				
18. CAUSE OF DEATH 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) DUE TO _____ (B) DUE TO _____ (C) DUE TO _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/16/67									
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY			23D. LOCATION (City, town, or county) (State)		
Burial		June 20/67		Mt Calvary Cem			A. G. County, Md		
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR			24C. FUNERAL DIRECTOR			ADDRESS	
JUN 19 1967		Robert E. Farber			Frank E. Flickner			1129 N. Carroll St	

(2)

July 1912

High Mountain

Green Mountain 4183 2000

Mountain Lake

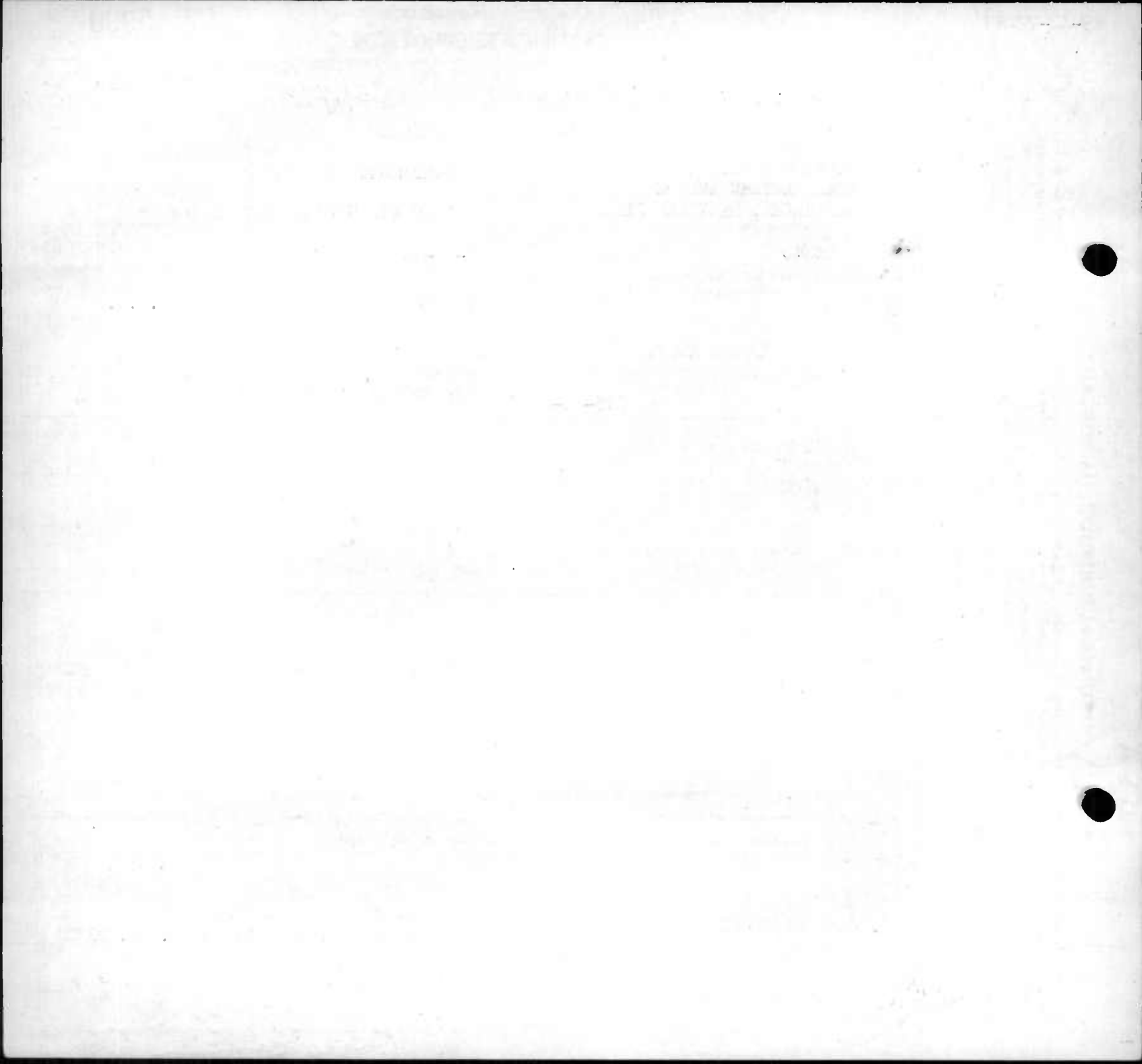
ADOLE

These figures are for the year 1912
and are for the year 1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5900	
BIRTH NO. 67 5900				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lucinda Moir (Moyer)		2. DATE AND HOUR OF DEATH 6/17/67 6:25 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9-09	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location) 1520 AISQUITTH STREET 21202	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-10-96	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JESSIE ADAMS	
14. MOTHER'S MAIDEN NAME ANABEL GILES				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 215-32-6532				17. INFORMANT ADDRESS BCH:RECORDS 4940 EASTERN AVENUE 21224	
18. 260 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) C.V.A. DUE TO (B) A.S.C.V.D. - generalised DUE TO (C) Diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH 2 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Urinary tract infection					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from June 6 19 67 to June 17 19 67 , that (H) (we) last saw the deceased alive on June 17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carl Winterstein				23B. DATE SIGNED 6/17/67	
23C. PHYSICIAN'S NAME (Type) DR. CARL WINTERSTEIN				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTO. MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6/21/67		24C. NAME of CEMETERY or CREMATORY DANVILLE, VA.	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR Robert E. Jackson		24F. FUNERAL DIRECTOR ADDRESS 1129 N. Caroline St	
24G. DATE REC'D BY HEALTH DEPT. JUN 19 1967		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR	



49-32-51
IW

67 5901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 5901

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DEROSA, Alfonso

2. DATE AND HOUR OF DEATH

6-15-67

12:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)31 BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

717 UMBRA STREET - 21224

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

4/29/89

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Barber

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

ITALY

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

DECEASED Vincent DECEASED DeRosa

14. MOTHER'S MAIDEN NAME

DECEASED Elizabeth

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
339-09-9629

17. INFORMANT Records:

ADDRESS

BALTO. CITY HOSPITALS, 4940 Eastern Ave.,
BALTO. MD. 21224

18. 420.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Myocardial Infarction
DUE TO

3 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) HASCVD
DUE TO

Over 10 years

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-22 19 67 to 6-15 19 67.
that (I) (we) lost saw the deceased alive on 6-15-67 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David J. Mishelevich

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6-15-67

23C. PHYSICIAN'S
NAME (Type)

DAVID J. MISHELEVICH

M.D.

23D. ADDRESS BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE, BALTIMORE, MD. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-17-67

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 20 1967

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

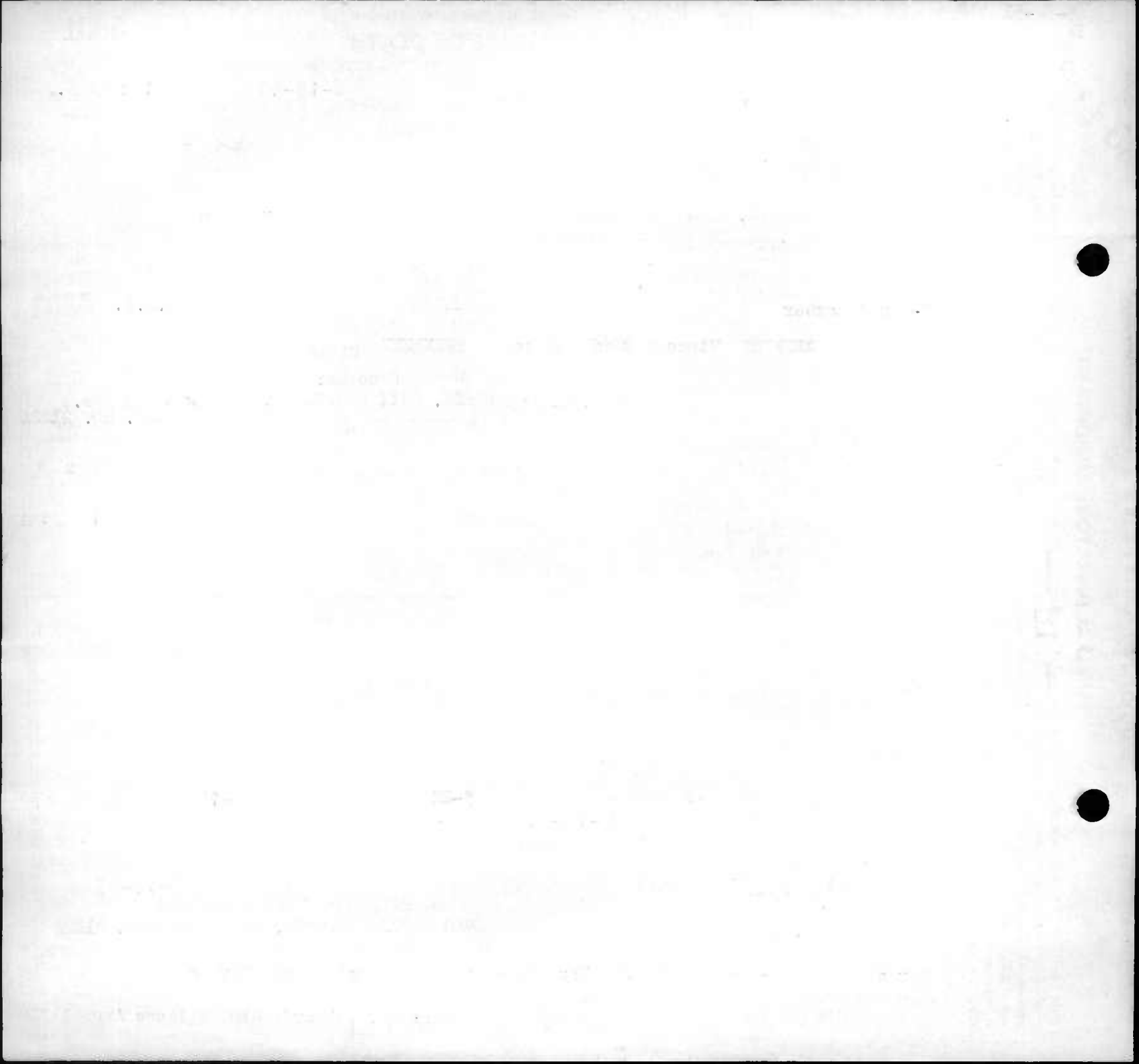
25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

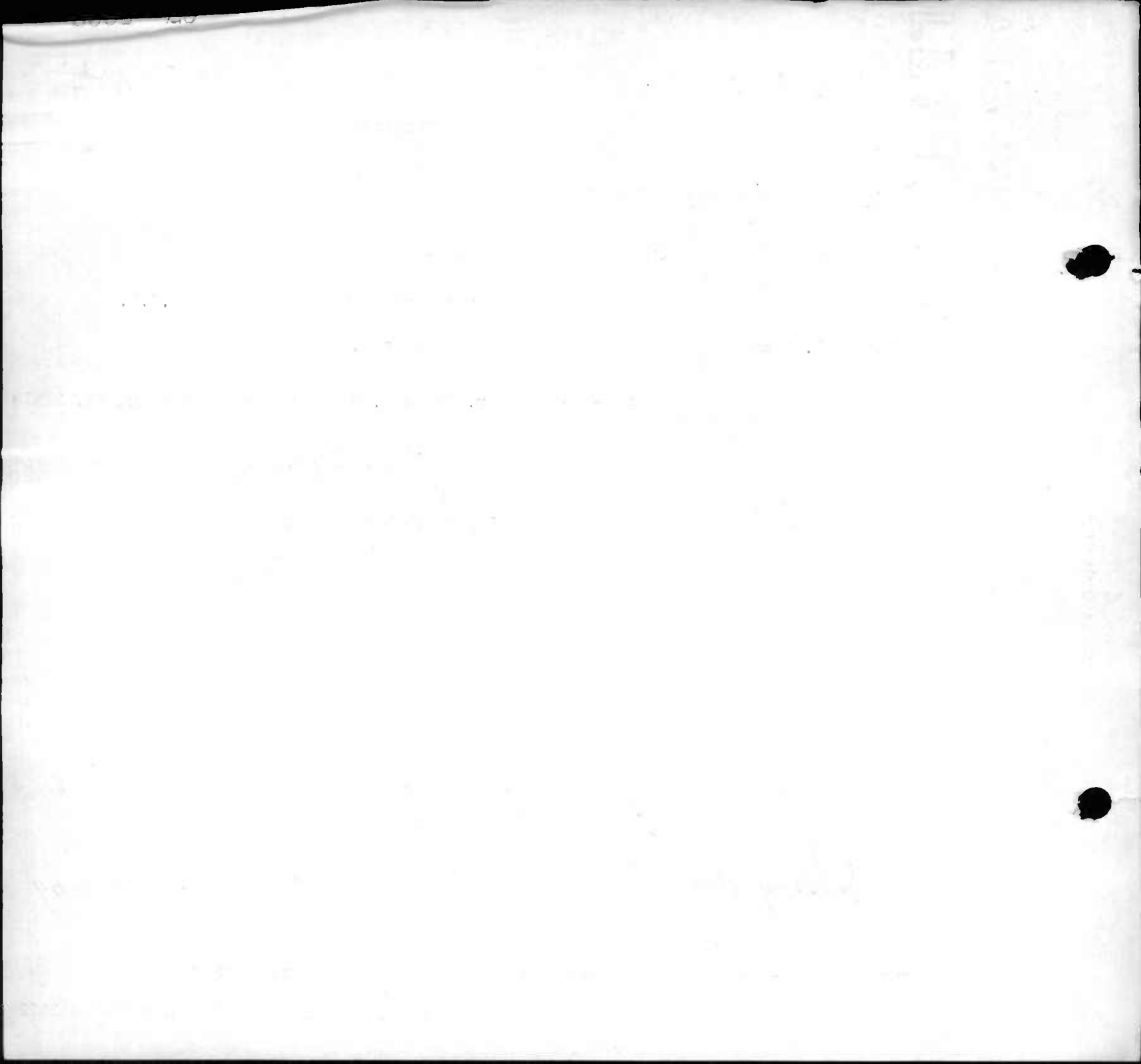
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

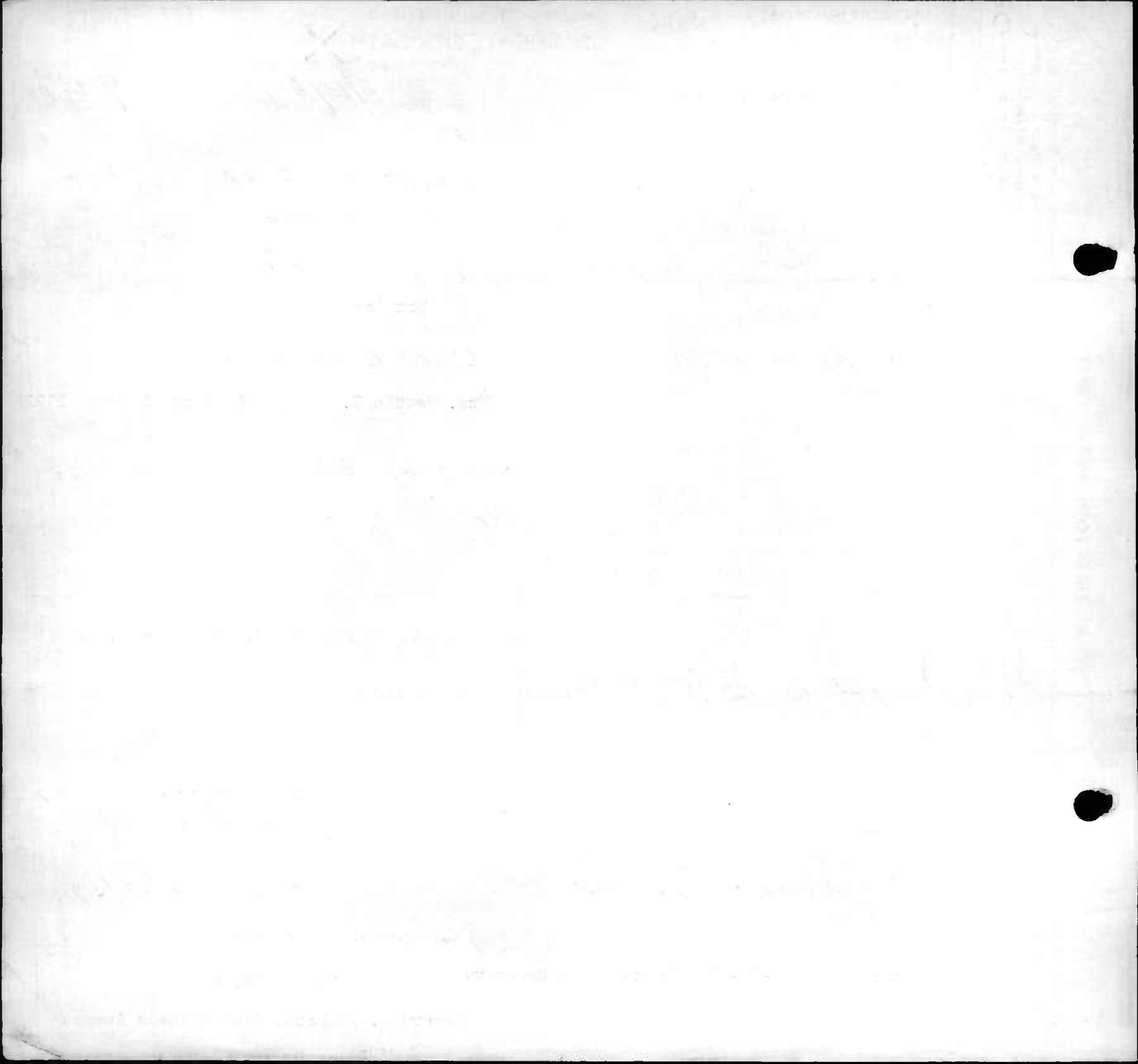
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5302</u>	
67 5902					
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
<u>Woolford, Anna E.</u>		<u>Franklin Square Hospital</u>		<u>June 14, 1967</u> <u>7:30</u> <u>A</u> M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
<u>Franklin Square Hospital</u>		<u>Maryland</u>		<u>25-33</u>	
5. SEX		6. RACE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
<u>F</u>		<u>white</u>		<u>Baltimore</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
<u>married</u>		<u>9-29-1889</u>		<u>77</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Housewife</u>				<u>Baltimore, Maryland</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<u>Joseph A. Abey</u>		<u>Anna M.</u>		<u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		<u>216-32-9919</u>		<u>Mr. Wayne H. Woolford, 2443 Westport St. 21230</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>acute pul. edema</u> DUE TO		<u>from 2 yrs. ago</u>	
		(B) <u>acute myocardial infarction</u> DUE TO		<u>to June 14, 67</u>	
		(C) <u>Diabetes mellitus</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 11</u> 19 <u>67</u> to <u>June 14</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 14</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Samuel Bae</u> M.D., Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>June 14, 67</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<u>Burial</u>		<u>6-17-67</u>		<u>Loudon Park Cemetery</u>	
				24D. LOCATION (City, town, or county) (State)	
				<u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<u>JUN 20 1967</u>		<u>Robert E. Taylor</u>		<u>Howard H. Hubbard, 4107 Wilkens Avenue 21229</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

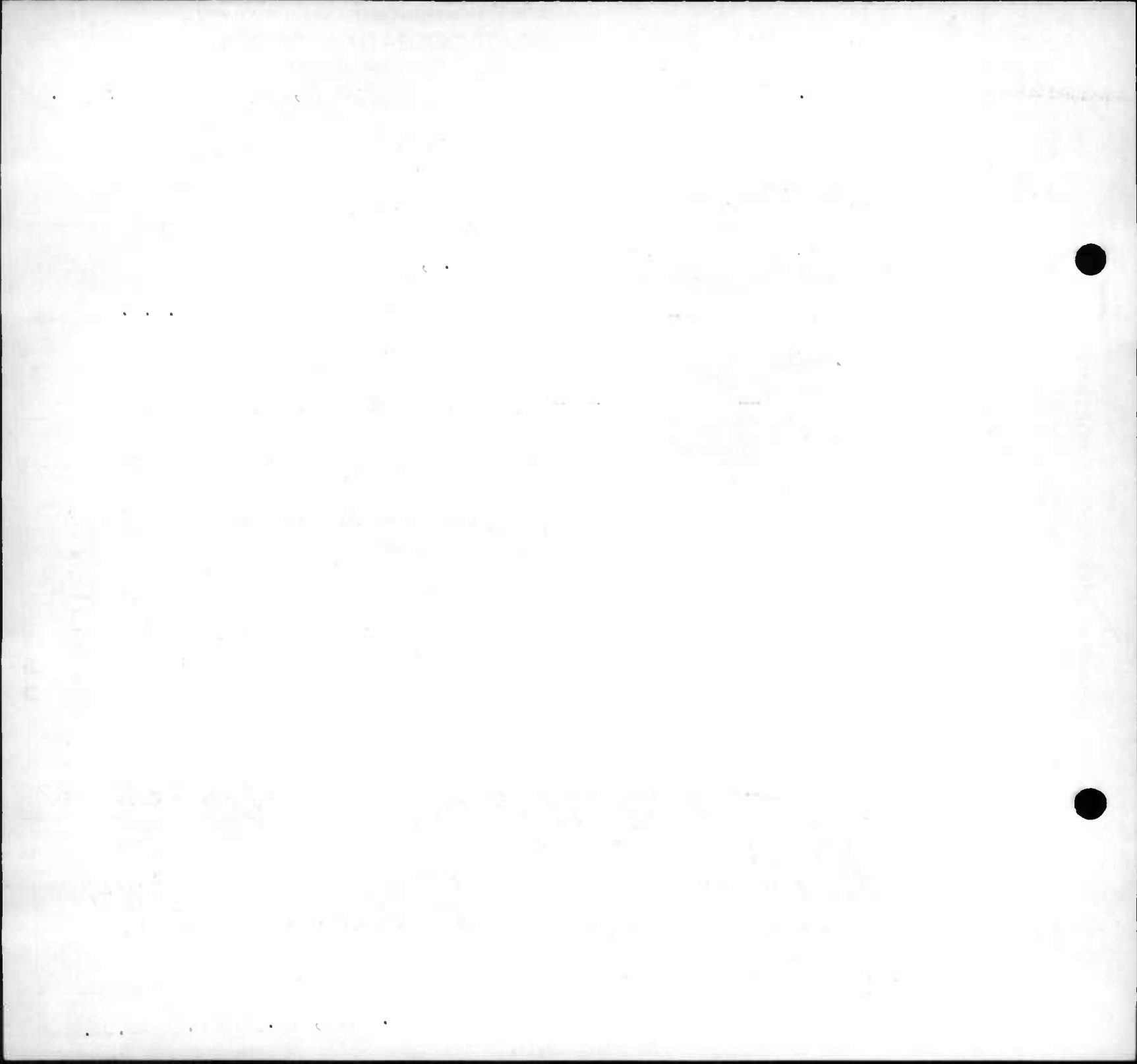
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5903	
CERTIFICATE OF DEATH				67 5903	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		OTTO, EARL HENRY		6/13/67 9:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		UNIVERSITY HOSPITAL		MD. Balt. Co.	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
M		W		MARRIED	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
5/30/98		69		B+O Railroad	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Maryland		USA		HENRY W. OTTO	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
LYDIA E. RELLEKER					
17. INFORMANT		ADDRESS		Mrs. Nettie I. Otto, 5728 First Avenue 21227	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
(A) DUE TO		PULMONARY EMBOLISM		30 min.	
(B) DUE TO		ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE			
(C) DUE TO					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		STATUS POST-OP ILEAL LOOP DIVERSION FOR NEUROGENIC BLADDER	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
6/2/67		NEUROGENIC BLADDER			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/21 1967 to 6/13 1967, that (I) (we) last saw the deceased alive on 6/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
		Graham J. Suger M.D.		6/13/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-16-67		Laurel Hill Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 20 1967		Robert E. S. S. S.		Howard H. Hubbard, 4107 Wilkens Avenue	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5904	
BIRTH NO. 67 5904		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH June 17, 1967 2:45 A. M.			
1. NAME OF DECEASED (Type or Print) J. Oliver Smith					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-12			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5310 Tilbury Way		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 5310 Tilbury Way			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 8, 1899	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph M. Smith			14. MOTHER'S MAIDEN NAME Caroline Eney		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 274-01-3623		17. INFORMANT ADDRESS Mrs Norbert Zeller 5310 Tilbury Way	
18. 4-22-1 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) CONGESTIVE HEART FAILURE DUE TO 2 MONTHS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,			(B) ARTERIOSCLEROTIC C-V. DISEASE DUE TO YEARS		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CEREBRAL ARTERIOSCLEROSIS YEARS					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from APRIL 12, 1967 to JUNE 17, 1967 , that (I) (we) last saw the deceased alive on JUNE 15, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Arthur Karfain				23B. DATE SIGNED 6/19/67	
23C. PHYSICIAN'S NAME (Type) ARTHUR KARFAIN				23D. ADDRESS 1532 HAVENWOOD ROAD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/20/67		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS John A. Moran, Inc. 3000 E. Balto. St.	



CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)*Lillian Elizabeth Meagher*

2. DATE AND HOUR OF DEATH

6-17-67 4:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)*31*
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

108 North Curley Street 21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

*11-25-1887*9. AGE (In years
last birthday)*79*

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Maryland*12. CITIZEN OF
WHAT COUNTRY?*U.S.A.*

13. FATHER'S NAME

George Smith

14. MOTHER'S MAIDEN NAME

*Catherine*15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)*no*16. SOCIAL
SECURITY NO.*215-03-7257A*

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18.

*609 X1*DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C)

Sepsis
*UTI, decubiti*INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.*Chronic brain syndrome*

19A. DATE OF OPERATION

*None*19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED*No*

20A. AUTOPSY? (Yes or No)

*No*20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)*No*21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) this hospital attended the deceased from *7-22* 19 *66* to *6/17* 19 *67*,
that (I) we last saw the deceased alive on *6-17* 19 *67* and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) We (did) (did not) view the body after death.

23A. SIGNATURE

J.T. Davidson

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

*6/17/67*23C. PHYSICIAN'S
NAME (Type)*J.T. Davidson*

M.D.

23D. ADDRESS

*4940 Eastern Avenue, Baltimore,
Maryland*24A. BURIAL CREMATION,
REMOVAL (Specify)*Burial*

24B. DATE

6/20/67

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

*Baltimore**Maryland*

25A. DATE REC'D BY HEALTH DEPT.

JUN 20 1967

25B. NAME OF REGISTRAR

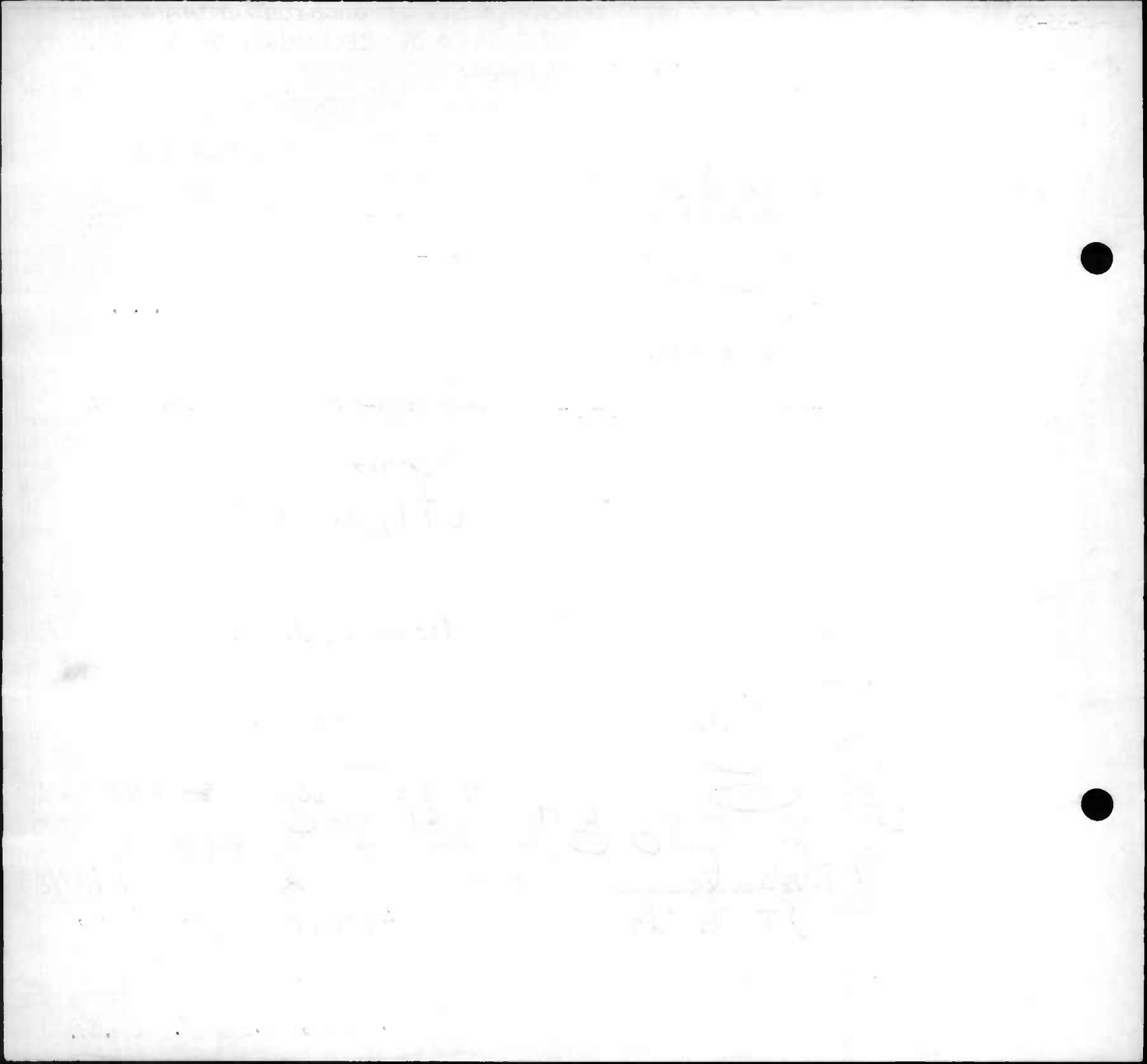
Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Balto. St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		P.	
				Emmanuel O. Sanios		6-17-67		3:00 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224					A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 731 S. Oldham Street #21224				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-22-1907	9. AGE (In years lost birthday) 59	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -			10B. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? Greece		
13. FATHER'S NAME Georgios (Deceased)					14. MOTHER'S MAIDEN NAME Elena (Deceased)				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. -		17. INFORMANT BCH 4940 Eastern Avenue RECORDS: Baltimore, Maryland #21224				
18. 583X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Liver disease ? etiology 6 weeks (B) DUE TO (C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Thalassemia minor Lifetime				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5/29/67 19 to 6/17/67 19, that (I) (we) last saw the deceased alive on 6/17/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Bruce M. Dow					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/17/67		
23C. PHYSICIAN'S NAME (Type) Bruce M. Dow			23D. ADDRESS BCH 4940 Eastern Avenue Baltimore, Maryland #21224						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/20/67		24C. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967			25B. NAME OF REGISTRAR Robert E. Fairley, M.D.		25C. FUNERAL DIRECTOR Nicholas J. Matthews		ADDRESS 3021 Eastern Ave. Baltimore, Md.		

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B-420

67 5907

BALTIMORE CITY HEALTH DEPARTMENT

67 5907

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)
DAISY

BLAKE

2. DATE AND HOUR PRONOUNCED DEAD

June 18, 1967

9:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

LUTHERAN HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2125 Pulaski Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

W.

8. DATE OF BIRTH

12/24/1900

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Charlotte, N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

1B.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/19/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

6/22/67

23C. NAME of CEMETERY or CREMATORY

Covered Menard Park Cemetery, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 20 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

1712 W. Waverly Ave

QUALITY PAPER

QUALITY PAPER

QUALITY PAPER

QUALITY PAPER

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QUALITY PAPER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5908	
BIRTH NO. 67 5908		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM L. FOWLKES			
2. DATE AND HOUR OF DEATH 6-16-67 7:35PM M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 3.3			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) PHOENIX D. STREET ADDRESS (If rural, give location) PAPER MILL ROAD			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-13-04	9. AGE (In years lost birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grader operator		10B. KIND OF BUSINESS OR INDUSTRY contractors		11. BIRTHPLACE (State or foreign country) Ind.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME GEORGE FOWLKES			
14. MOTHER'S MAIDEN NAME ESTELLE ROBINSON		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 216-16-9874		17. INFORMANT Tertrude Fowlkes - Phoenix, Ind.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 177X I		CAUSE OF DEATH (A) Carcinoma of prostate (B) 6 years (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive heart failure			
19A. DATE OF OPERATION 0 time		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/13/67 19 to 6/16/67 19, that (I) (we) last saw the deceased alive on 6/16/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John S. Sargent		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-16-67	
23C. PHYSICIAN'S NAME (Type) JOHN S. SARGENT		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/20/67		24C. NAME OF CEMETERY OR CREMATORY St. Lukes	
24D. LOCATION (City, town, or county) (State) Hereford, Balto. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. J. Chatman Jr.		ADDRESS 1701 Mt. Culloden St. Balto. Md.	

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67 5909

BALTIMORE CITY HEALTH DEPARTMENT

67 5909

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

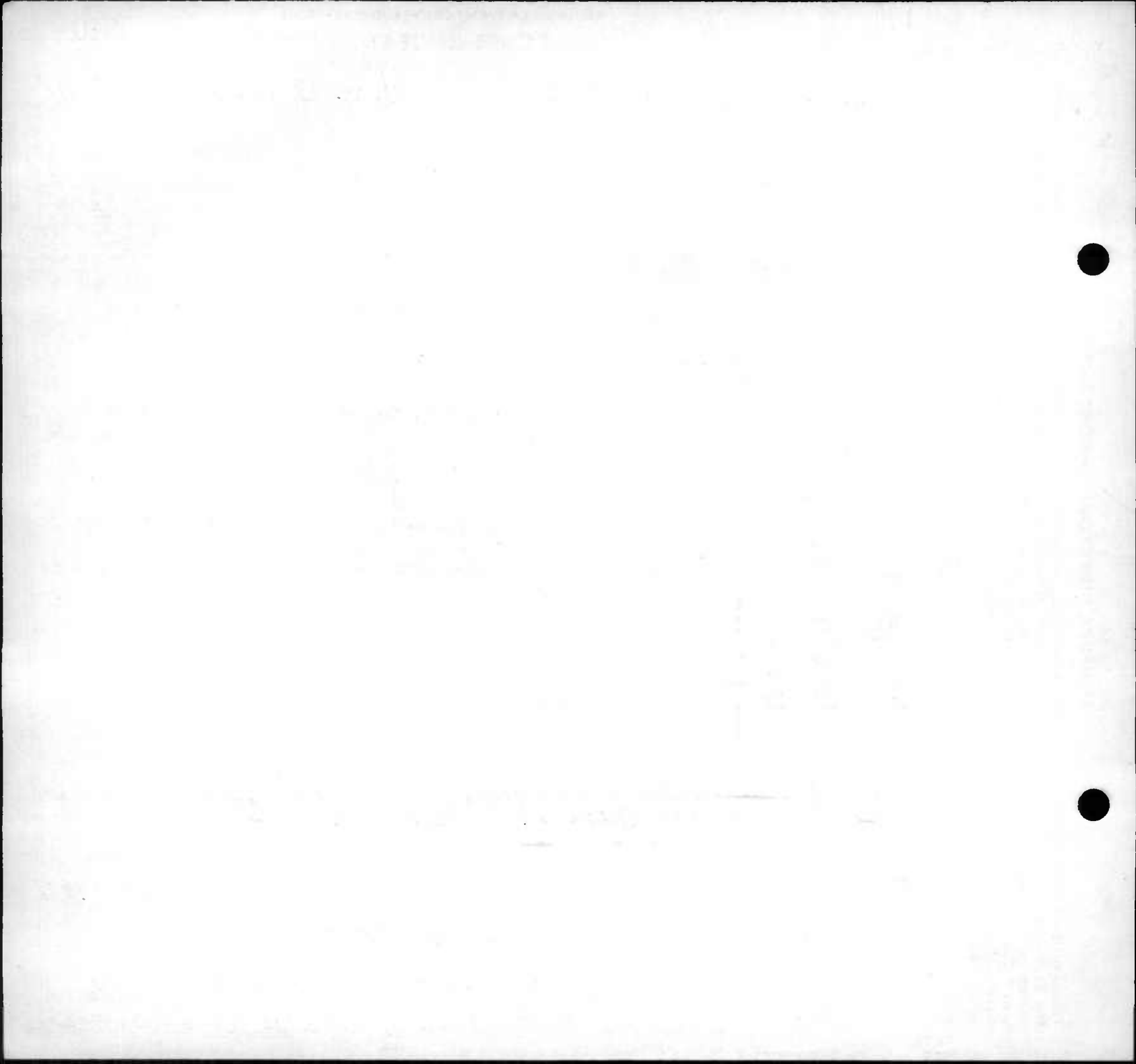
1. NAME OF DECEASED (Type or Print) HOWARD ORR				2. DATE AND HOUR PRONOUNCED DEAD June 16, 1967 8:00 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 340 South Macon Street				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 26-07 D. STREET ADDRESS (If rural, give location) 340 South Macon Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 19, 1909	9. AGE (In years last birthday) 57 50	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wire mill		10B. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Orr				14. MOTHER'S MAIDEN NAME Sarah Jane ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Elma Orr 605 S. Tolna St.,			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (partial)				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate		M.D. Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 17, 1967	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/21/67		23C. NAME OF CEMETERY or CREMATORY Wildwood Cemetery		23D. LOCATION (City, town, or county) (State) Williamsport, Pa.	
24A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		24B. NAME OF REGISTRAR Robert E. Taylor		24C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home Dundalk, Md.			

WILLY PAPER
PAPER AND CONTENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5910	
BIRTH NO. 67 5910				CERTIFICATE OF DEATH	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) ARTHUR T. NICHOLS			JUNE 18 1967 3:15 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 4108 EIERMAN AVE			A. STATE MARYLAND B. COUNTY BALTIMORE		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 4108 EIERMAN AVE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH DEC. 11, 1893	9. AGE (In years lost birthday) 73	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME ORA T. NICHOLS			14. MOTHER'S MAIDEN NAME LYDIA WRIGHTSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		
			17. INFORMANT MRS LOU NICHOLS 4108 EIERMAN		
			ADDRESS		
18. 443X			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Pulmonary Edema		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Cardio-Vascular Hypertensive Disease - 8 years		
			(C) Atherosclerosis		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
			1 day		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
D					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (the hospital) attended the deceased from March 1959 to June 18, 1967 , that (I) last last saw the deceased alive on June 17, 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did) not view the body after death.					
23A. SIGNATURE Michael J. Dausch			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 18, 1967
23C. PHYSICIAN'S NAME (Type) MICHAEL J. DAUSCH			23D. ADDRESS 4636 BELAIR ROAD		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 6/21/67		24C. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY
24D. LOCATION (City, town, or county) (State) PARKVILLE MD					
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967			25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ULLRICH FUNERAL HOME - 4210 BELAIR



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5911	
BIRTH NO. 67 5911				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		KELSO MARTHA JANE		2. DATE AND HOUR OF DEATH JUNE 19 1967 7:05A	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED 40 ST AGNES HOSPITAL 6-26-67				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 24 JEFFREY ST.	
5. SEX F WHITE	6. RACE W FEMALE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) UNKNOWN	8. DATE OF BIRTH 1-27-10	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penn	
13. FATHER'S NAME WILLIAM ROBERT Parks Robert Buckley			14. MOTHER'S MAIDEN NAME MARGARET PARKS Koolby Margaret Parks		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 2		17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.11 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized atherosclerosis - principal Antecedent Causes Heart - recent myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 16 1967 to JUNE 19 1967 , that (I) (we) last saw the deceased alive on JUNE 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. George Angov				23B. DATE SIGNED 6-19-67	
23C. PHYSICIAN'S NAME (Type) L. GEORGE ANGOV		23D. ADDRESS CATON & WILKENS AVE. BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-22-1967		24C. NAME OF CEMETERY or CREMATORY L.O.O.F.	
24D. LOCATION (City, town, or county) (State) Broadtop. Penn.		25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS F.C. Higginbotham, Ellicott City, Md. for Masood Funeral Home, Saxton, Pa.			

V.S. 153

6-26-67

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5912 CERTIFICATE OF DEATH					Registered No. 67 5912				
BIRTH NO. 67 5912					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) DONAVAN MYERS					2. DATE AND HOUR OF DEATH 6-17-67 8:40 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Balto Co				
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00				
D. STREET ADDRESS (If rural, give location) 1932 SUMMIT AVE									
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 12-17-1900	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER			10B. KIND OF BUSINESS OR INDUSTRY PLUMBING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME IRA B. MYERS					14. MOTHER'S MAIDEN NAME GOLDA - ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 215-093835		17. INFORMANT BROTHER IN LAW				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Cardiac Arrest due to Severe extensive myocardial infarction ASCVD (B) Massive Hemorrhage due to Duodenal Ulcer + Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH minutes 2 days Unknown			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arteriosclerosis									
19A. DATE OF OPERATION 6-17-67			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding Duodenal Ulcer			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-17-67 to 6-17-67, that (I) (we) last saw the deceased alive on 6-17-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Donald B. Hebb					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-17-67		
23C. PHYSICIAN'S NAME (Type) DONALD B. HERB					23D. ADDRESS 111 W MONUMENT ST BALTO MD				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE June 21/67		24C. NAME OF CEMETERY or CREMATORY Pleasant Grove		24D. LOCATION (City, town, or county) (State) Balto. Co. MD.		
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967			25B. NAME OF REGISTRAR Charles E. Taylor			25C. FUNERAL DIRECTOR John T. Stansbury		ADDRESS 6411 Windsor Mill Rd.	

Cardinal Forest
2000 ft. elevation
2000 ft. elevation
2000 ft. elevation
2000 ft. elevation

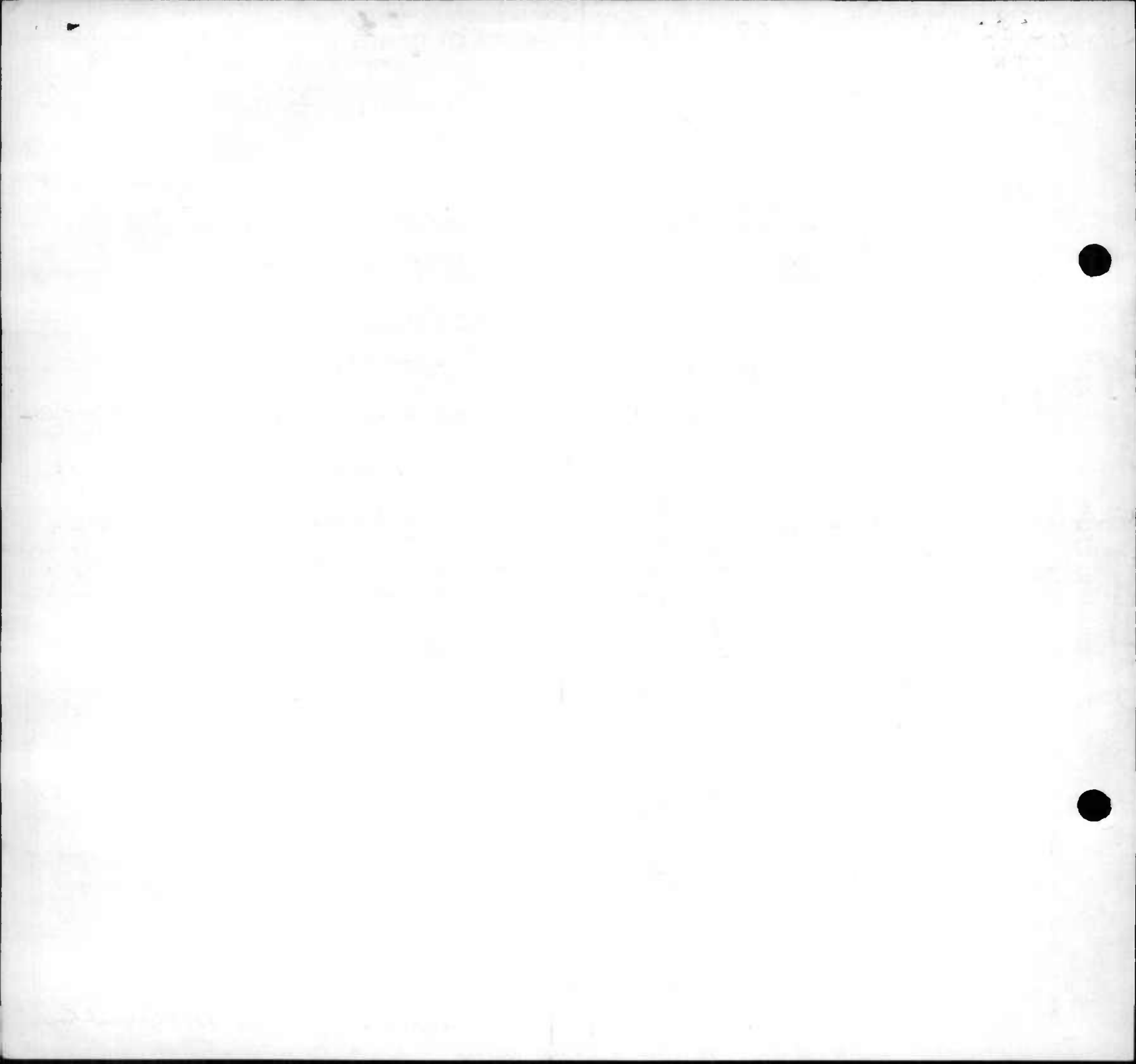
General and Historical Notes

10-11-12 10-11-12 10-11-12

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5913	
BIRTH NO. 67 5913		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Joseph Slemaker		2. DATE AND HOUR OF DEATH June 17th 1967 1:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Sinai Hospital of Baltimore FULL NAME OF HDSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3331 Spaulding Ave			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/12/03	9. AGE (In years last birthday) 62	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIPPING		10B. KIND OF BUSINESS OR INDUSTRY KOONZ CREAMERY.		11. BIRTHPLACE (State or foreign country) BALTO, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME JOHN H. SLEMAKER		14. MOTHER'S MAIDEN NAME JOSEPHINE GRIFFITH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-10-3613		17. INFORMANT ANNA E. SLEMAKER- 3331 SPAULDING AVE	
18. 502.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Electrolyte Imbalance & Acidosis DUE TO (B) Chronic Obstructive Emphysema DUE TO (C) Chronic Bronchitis		INTERVAL BETWEEN ONSET AND DEATH 10 days Unknown Unknown	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6/20/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 9th 1967 to June 17th 1967 , that (I) (we) last saw the deceased alive on June 17th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William Cieplinski M.D.				23B. DATE SIGNED 6/17/67	
23C. PHYSICIAN'S NAME (Type) William Cieplinski				23D. ADDRESS Sinai Hospital of Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/20/67		24C. NAME OF CEMETERY or CREMATORY Morland Memorial Park	
24D. LOCATION (City, town, or county) (State) Taylor Ave, Md					
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Austin E. Donovan- 3818 Roland Ave	



FUNERAL DIRECTOR: IMPORTANT

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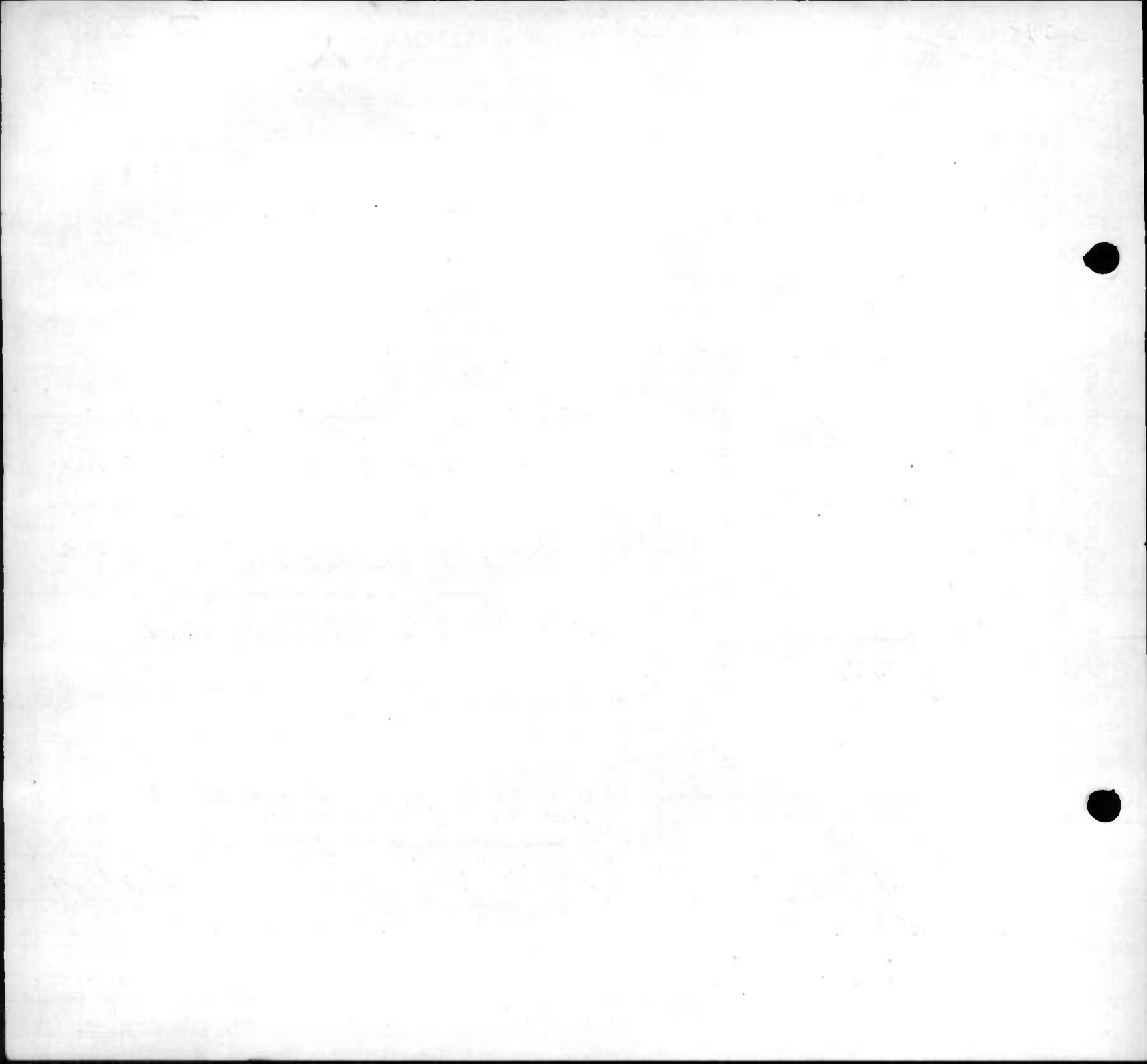
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5914	
BIRTH NO. 67-1143267 5914				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Girl RAQUEL			
2. DATE AND HOUR OF DEATH		JUNE 18, 1967 7⁵³ A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY Balto. Co.			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Md. GEN. Hosp.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) FORT HOWARD			
		D. STREET ADDRESS (If rural, give location) Bldg. 22 A. VA Hosp. Compound			
5. SEX FEMALE	6. RACE Filipino	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NB	8. DATE OF BIRTH JUNE 12, 1967	9. AGE (In years lost birthday) 6	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOSE A. RAQUEL, Jr.		14. MOTHER'S MAIDEN NAME Agapita TEMMATZY		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS MOTHER SAME	
18. 759.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) bronchopneumonia		(A) DUE TO		(B) multiple anomalies	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ① Atrial-septal defect. ② cleft palate					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald Gindhart				23B. DATE SIGNED 6/18/67	
23C. PHYSICIAN'S NAME (Type) DONALD GINDHART				23D. ADDRESS Md. Maryland General Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/19/67		24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Jesus	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967			
25B. NAME OF REGISTRAR Robert E. Fisher, MA		25C. FUNERAL DIRECTOR ADDRESS Walter & Charles Bradley, Inc. - Huntville			

Received by phone - Race of Baby from. Hosp. Records 6-22-67 L.M.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5915	
67 5915				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				CLARA MAY LINDSEY	
2. DATE AND HOUR OF DEATH		June 18, 1967 5:55 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium 6116 Bel Air Road Baltimore, Maryland		A. STATE Md. B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) White March D. STREET ADDRESS (If rural, give location) Box 374A Philadelphia Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept. 26, 1898	9. AGE (In years last birthday) 68	If Under 1 Tr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Hydes, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME J. Henry Mullenburg		14. MOTHER'S MAIDEN NAME Sarah Allen	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-09-7273-B		17. INFORMANT Fred Lee Lindsey, Box 374A Phila. Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebral Hemorrhage 36 hrs. (B) Cerebral Arteriosclerosis 4 yrs. (C) Arteriosclerotic Cardio. Dis. 6 yrs.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Hysterectomy for Carcinoma 1962			
19A. DATE OF OPERATION 2 1962		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from May 19 1967 to June 18 1967, that (I) (we) last saw the deceased alive on June 17, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. (5:55 A.M.)					
23A. SIGNATURE Clifford F. Hudson		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/19/67	
23C. PHYSICIAN'S NAME (Type) Clifford F. Hudson		23D. ADDRESS Fork, Baltimore Co., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 20, 1967		24C. NAME OF CEMETERY or CREMATORY Cemetery Wilson Methodist Church	
24D. LOCATION Long Green		Balto. Co., Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.	



BALTIMORE CITY HEALTH DEPARTMENT

67 5916 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5916

BIRTH NO. _____ M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) CECELIA F. HOLMES		2. DATE AND HOUR PRONOUNCED DEAD June 18, 1967 11:45 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6300 Toone Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY X C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6300 Toone Street	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 20, 1927
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (In years last birthday) 40
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Mc Farland		14. MOTHER'S MAIDEN NAME Ida Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. John A. Holmes 6300 Toone St.

18. 722.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Rheumatoid Arthritis (A) DUE TO _____ (B) DUE TO _____ (C) DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED **6/18/67**

23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 6 22 67	23C. NAME of CEMETERY or CREMATORY Glen Haven	23D. LOCATION (City, town, or county) (State) Glen Burnie, A. A. Co. Md.
24A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		24B. NAME OF REGISTRAR Robert E. Spitz, M.D.	24C. FUNERAL DIRECTOR ADDRESS Mc Gilly 130 E. Fort Ave

VS 151-REV. 1/1/65

WALLEY FORD

WALLEY FORD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH						Registered No. 67 5917					
BIRTH NO. 67 5917						M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Lida P Shipley</i>						2. DATE AND HOUR OF DEATH 6-17-67 8pm 800 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) <i>49 North Charles General Hospital 28th and Charles St</i>						A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundel Co</i>					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Glen Burnie 52-00</i>					
						D. STREET ADDRESS (If rural, give location) <i>105 N Alview Terrace, Glen Burnie</i>					
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>		8. DATE OF BIRTH <i>12/16/182</i>		9. AGE (In years lost birthday) <i>84</i>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Housework</i>						10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Colora, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Hidman</i>						14. MOTHER'S MAIDEN NAME <i>Mary Wesley</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>						16. SOCIAL SECURITY NO. <i>216-46-2075</i>		17. INFORMANT <i>Mrs. Eleanor S. Soriano (Niece)</i>		ADDRESS <i>Same as 17. Charles West</i>	
18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>MASSIVE ATELECTASIS CONGESTIVE HEART FAILURE HYPERTENSIVE CARDIOVASCULAR DISEASE</i>						CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH					
19. DATE OF OPERATION <i>2</i>						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)						21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 6-17-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>R. Abousy</i>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-17-67			
23C. PHYSICIAN'S NAME (Type) <i>R. ABOUSY</i>						23D. ADDRESS <i>North Charles Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>June 2/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>West Nottingham Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Colora, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 20 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>R. Redington</i>		ADDRESS <i>Singleton Funeral Home Glen Burnie, Md.</i>					

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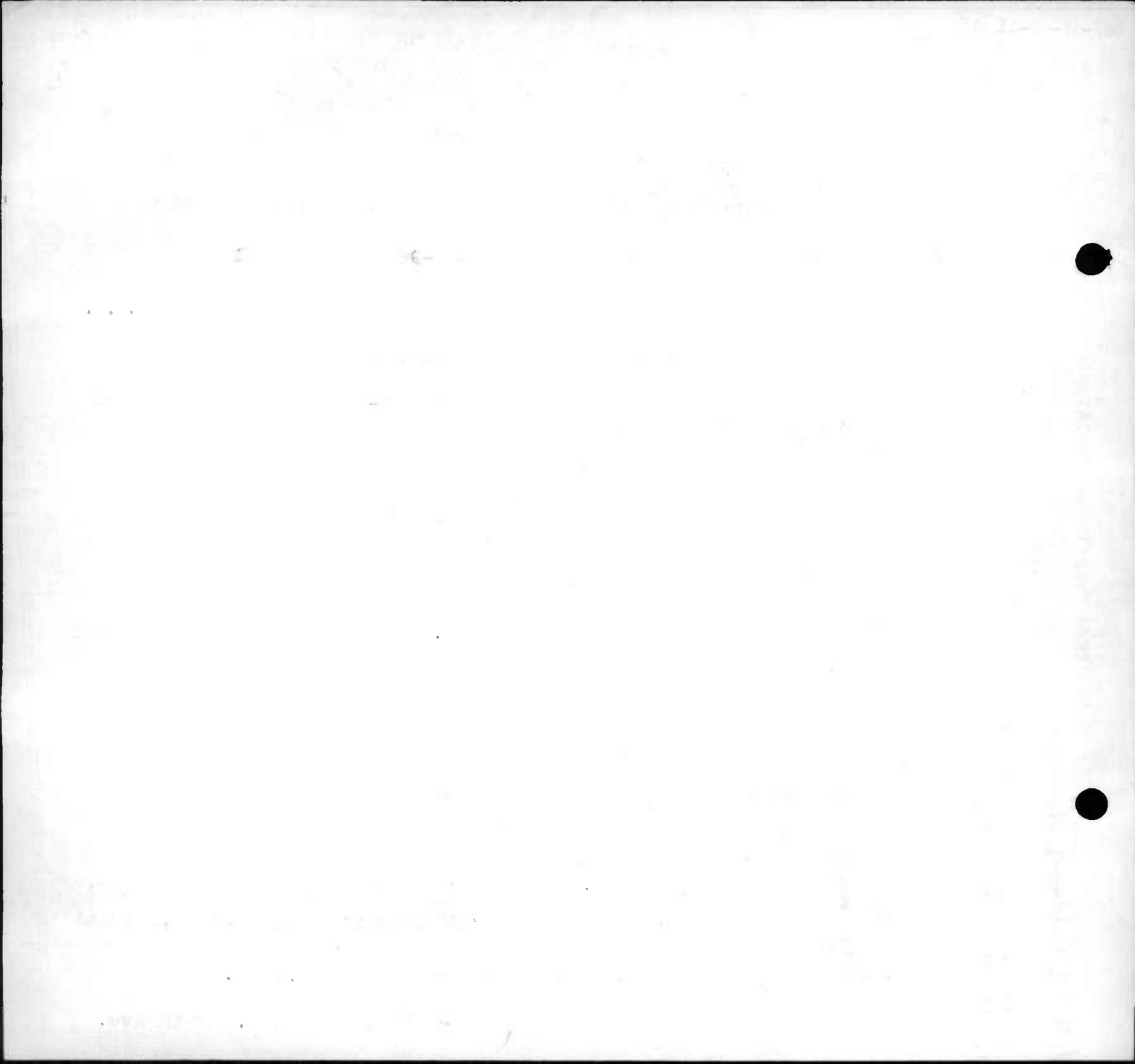
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N-250
M-435

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 5918		CERTIFICATE OF DEATH	
M.E. CASE NO.		Registered No. 67 5918	
1. NAME OF DECEASED (Type or Print) Sarah Moulder (Nixon)		2. DATE AND HOUR OF DEATH 6/18/67 6 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland B. COUNTY 7-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2546 Garrett Avenue 21218	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 5-10-96
9. AGE (In years last birthday) 71		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nixon		14. MOTHER'S MAIDEN NAME Margaret Nixon	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records: BCH-4940 Eastern Avenue 21224		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD Chronic renal disease ASHD		INTERVAL BETWEEN ONSET AND DEATH years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. multiple diabetes		mos.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/16 19 67 to 6/18 19 67 that (I) (we) last saw the deceased alive on 5/23/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE David Swimmer		23B. DATE SIGNED 6/18/67	
23C. PHYSICIAN'S NAME (Type) David Swimmer		23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/21/67	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E. North Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 5919

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

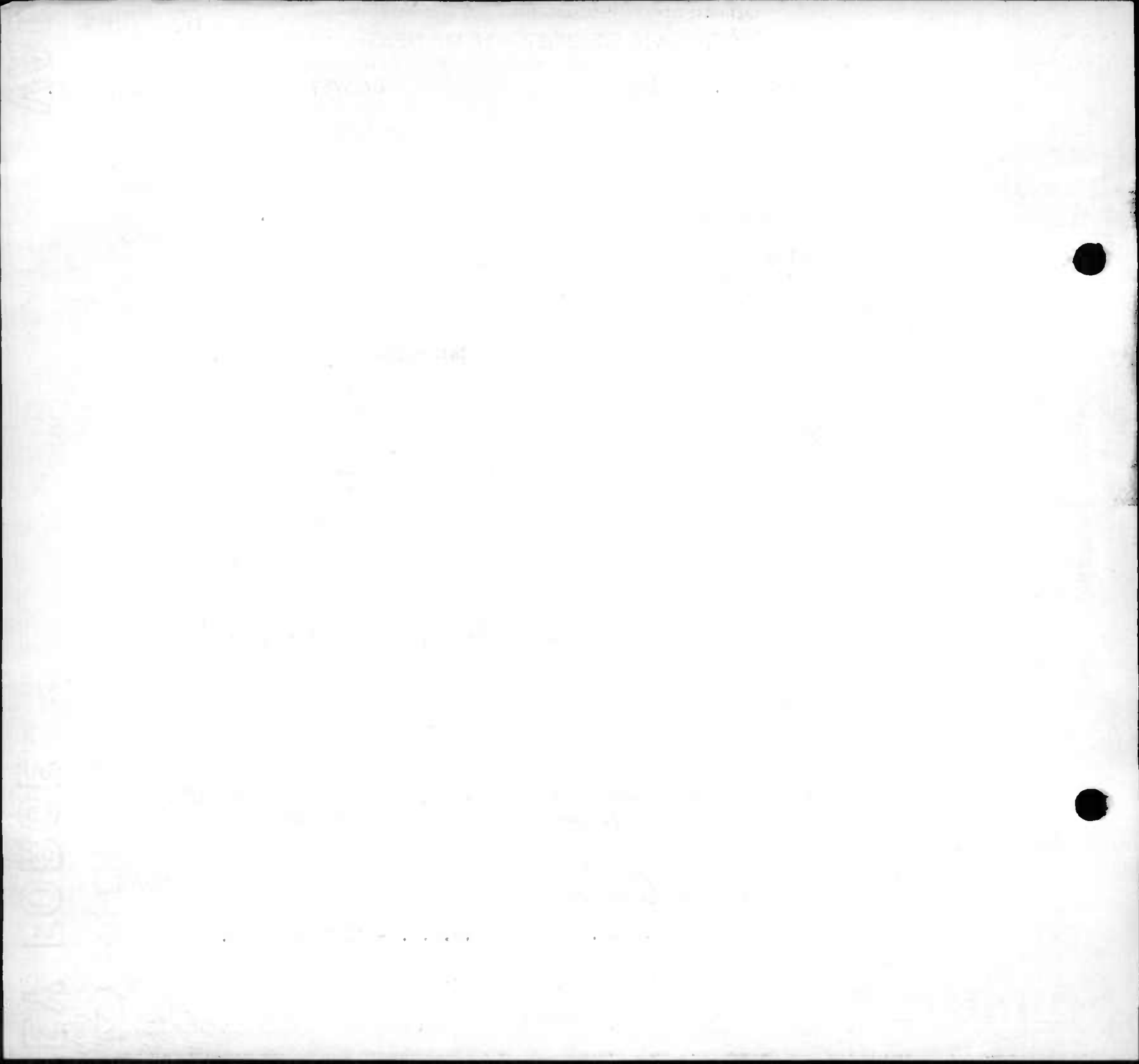
Registered No.

67 5919

BIRTH NO.		CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		TONTI, WYNETTE M.		6-18-67 10.15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
49 NORTH CHARLES GENERAL HOSPITAL		Md. W. S. A. Balto Co.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 53-00	
		D. STREET ADDRESS (If rural, give location)		3049 BERO RD. 21227	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
FEMALE	WHITE	WIDOWED	7-25-16	50	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
PACKER		Coca Cola Glass		Pa.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
MAURICE TONTI Pa		MATILDA OBENOUR			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
-		220-20-3006		NORTH CHARLES GENERAL HOSPITAL	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO		6 months.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-17-1967 to 6-18-1967 that (I) (we) last saw the deceased alive on 6-18-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
Chantlona Suddhimondala		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		6-18-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. PAUL SCHONFELD		5301 ANNAPOLIS RD. Balto. Md. 21227			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/21/67		Mount Airy Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 20 1967		Paul E. Taylor		Lassahn J. Taylor	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

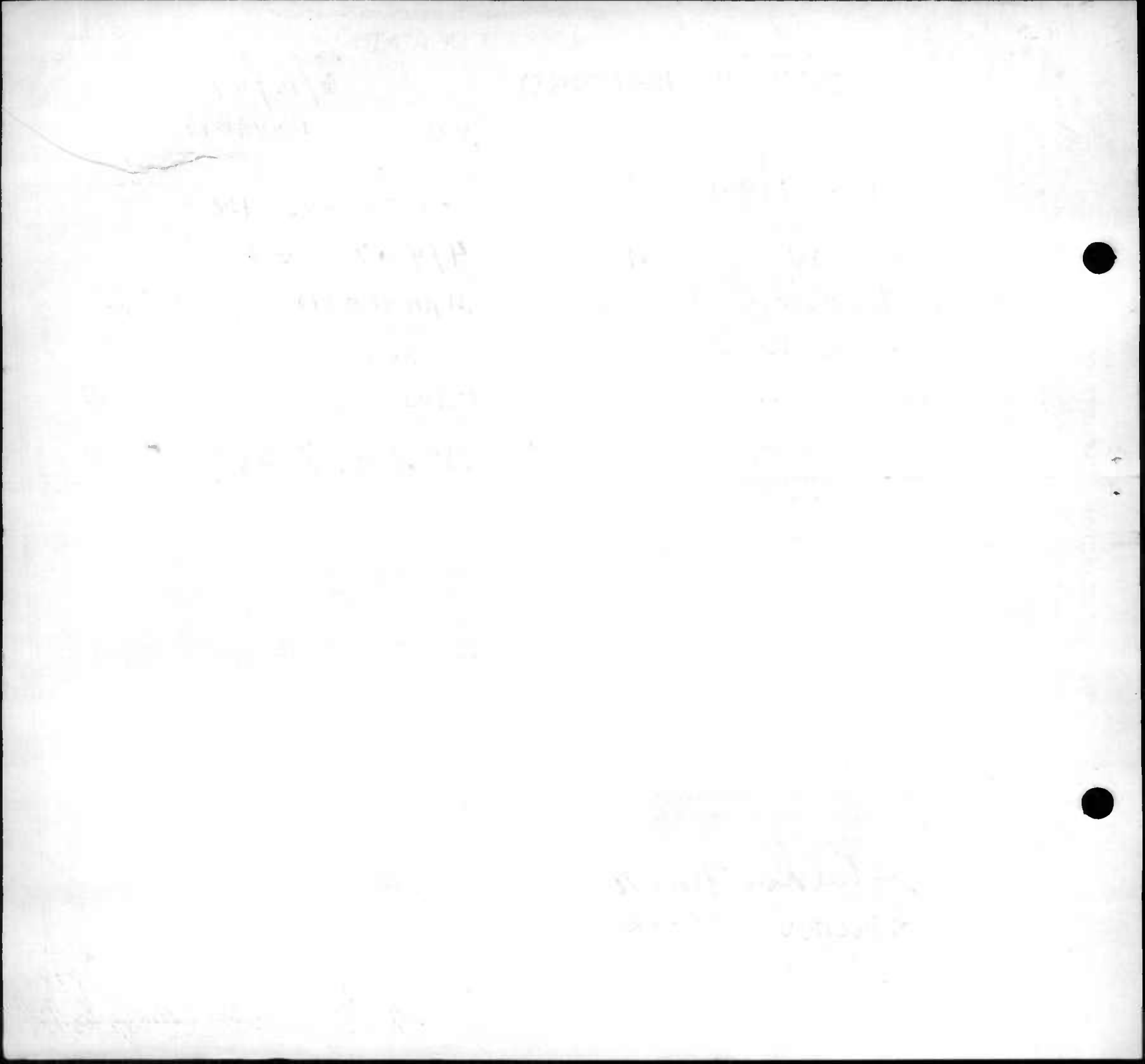
BIRTH NO. 67 5920		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5920	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Victor C. Schmidt			6/17/67 8:55 p. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF STREET OR INSTITUTION (If not in hospital or institution, give street address or location) 43 SOUTH BALTIMORE GENERAL HOSPITAL			A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 21-02 1106 Washington Blvd.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) S	8. DATE OF BIRTH 1/11/1893	9. AGE (In years last birthday) 74	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Worker		10B. KIND OF BUSINESS OR INDUSTRY Shoe Factory		11. BIRTHPLACE (State or foreign country) Md	
13. FATHER'S NAME Louis Schmidt			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			14. MOTHER'S MAIDEN NAME Catherine Heiser		16. SOCIAL SECURITY NO.
17. INFORMANT Charles Schmidt - Above			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 443X I CAUSE OF DEATH (A) C.V.A. - (possible pontine) Hemorrhage (B) H.A.S.C.V.D. (C)			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Mental Retard - (Birth injury)					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 6/10/67 19 to 6/17/67 19 that (X) (we) last saw the deceased alive on 6/17/67 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David J. Steinbauer M.D.				23B. DATE SIGNED 6/19/67	
23C. PHYSICIAN'S NAME (Type) DAVID STEINBAUER, M.D.				23D. ADDRESS S.B.G.H. - 1213 Light St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-21-67		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town or county) Baltimore		24E. STATE Md		24F. ZIP CODE	
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John J. Conant, Sr. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-163 67 5921 BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 5921	
M.E. CASE NO. EDMUND 1. NAME OF DECEASED (Type or Print) EDMOND BAFFORD		2. DATE AND HOUR OF DEATH 6/16/67			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY HOWARD CO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) CLARKSVILLE 63-00 D. STREET ADDRESS (If rural, give location) 106 TULANE DR.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 4/4/07	9. AGE (In years lost birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker		10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME C. W. Bafford			
14. MOTHER'S MAIDEN NAME Rebecca Barrett		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. —		17. INFORMANT Edna S. Bafford			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 157X I METASTATIC ADENOCARCINOMA OF PANCREAS		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		INTERVAL BETWEEN ONSET AND DEATH 2 MO.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sheldon Frank				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) SHELDON FRANK				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-20-67		24C. NAME OF CEMETERY OR CREMATORY Hillcrest	
24D. LOCATION (City, town, or county) Annapolis Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.			
ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5922	
BIRTH NO. 67 5922		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) STANSFIELD, ANDREW OSCAR		2. DATE AND HOUR OF DEATH JUNE 16, 1967 7:40 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Carroll Co.			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MD. 21229		C. CITY OR TOWN (If outside city limits, write RURAL and give township) SYKESVILLE 56-00			
		D. STREET ADDRESS (If rural, give location) CENTRAL POST OFFICE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 4/25/87	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10B. KIND OF BUSINESS OR INDUSTRY Farming UNKNOWN		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ANDREW STANSFIELD DEC 'D		14. MOTHER'S MAIDEN NAME DELIA (MARRS) STANSFIELD DEC 'D	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 218 14 6821		17. INFORMANT CATON & WILKENS AVES. 21229 HOSPITAL RECORDS-ST. AGNES HOSPITAL	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Massive frontal CVA. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Massive pulmonary congestion		CAUSE OF DEATH (A) Massive frontal CVA. (B) Massive pulmonary congestion (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2/		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 9, 19 67 to JUNE 16, 19 67 , that (X) (we) last saw the deceased alive on JUNE 16, 19 67 and that (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (diagnose) view the body after death.					
23A. SIGNATURE John B. Herts		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/17/67	
23C. PHYSICIAN'S NAME (Type) JOHN B. HERTS		23D. ADDRESS M.D. STAGNES HOSP. BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6-19-67	24C. NAME OF CEMETERY or CREMATORY Mt View Cemetery		24D. LOCATION (City, town, or county) (State) Sykesville, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		25B. NAME OF REGISTRAR Harry Hight		25C. FUNERAL DIRECTOR Sykesville, Md.	

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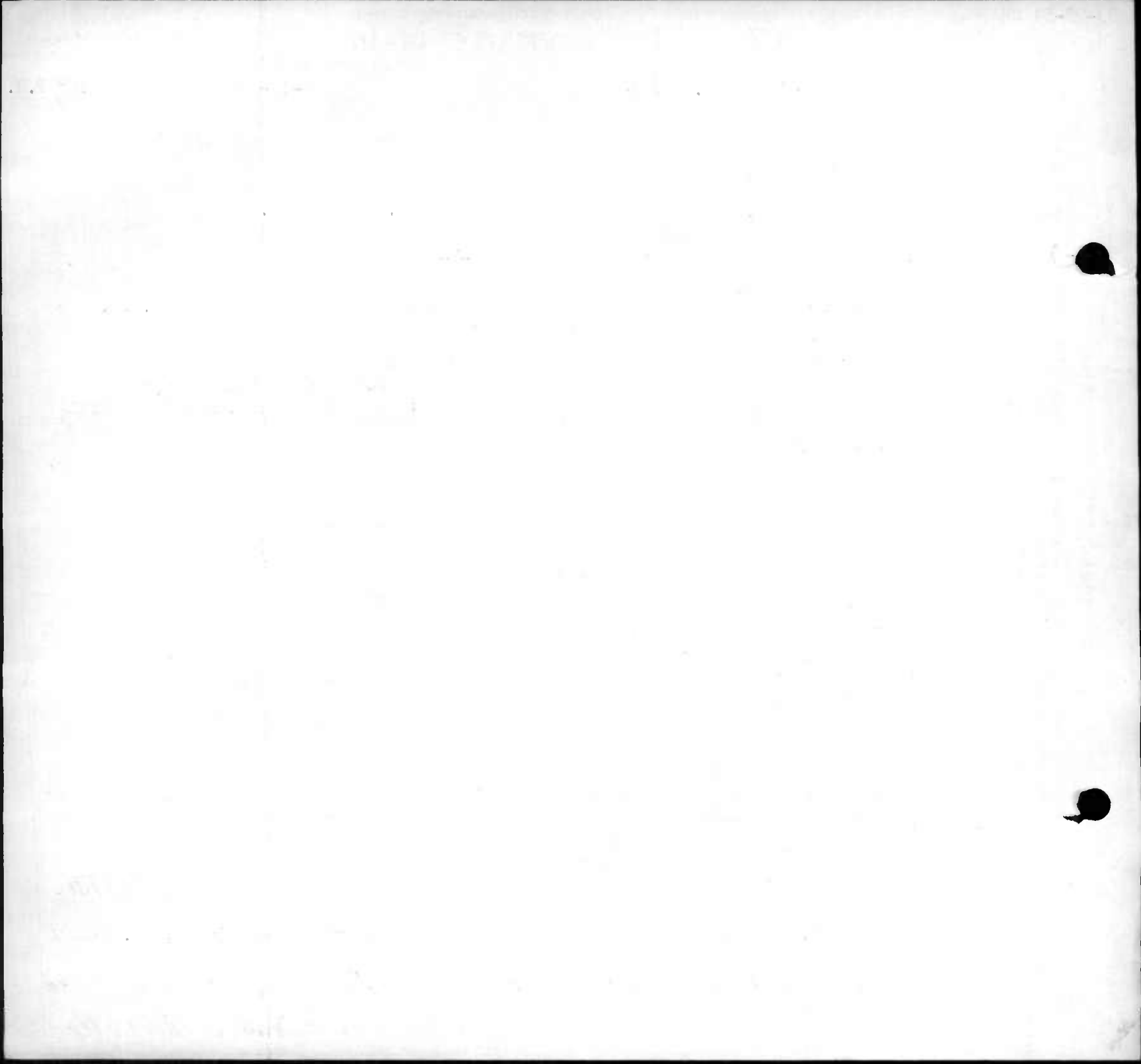
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 5923		CERTIFICATE OF DEATH		67 5923	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print)			6-15-67 10:45 P.M.		
William B. Settles					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland			Maryland		
31			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			1515 W. Lombard St. #21223		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	White	Divorced	7-8-06	60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
none				Virginia	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Unknown			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				BCM 4940 Eastern Avenue Baltimore, Maryland #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 6/15/67 to 6/15/67, that (1) last saw the deceased alive on 6/15/67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Monica M. Buckley				6/15/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Monica M. Buckley				4940 Eastern Avenue Baltimore, Md. #21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		6/19/67		GLENHAVEN	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 20 1967		Robert E. [Signature]		GEORGE GONCE 4001 Ritchie Hwy.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5924	
BIRTH NO. 67 5924				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Marion C. Wyatt				June 15, 1967 11:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Plaza Nursing Home 1515 N. Bruce Street				A. STATE Maryland B. COUNTY 14-01	
5. SEX Female 6. RACE Colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
8. DATE OF BIRTH Aug. 19, 1912 9. AGE (in years last birthday) 54				D. STREET ADDRESS (If rural, give location) 1726 Bolton Street	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				11. BIRTHPLACE (State or foreign country) Virginia	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. Smith				14. MOTHER'S MAIDEN NAME Pauline Nutt	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
17. INFORMANT Earl L. Wyatt				ADDRESS 1726 Bolton Street	
18. 334X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Insufficiency CAUSE OF DEATH Cerebral Arterial sclerosis INTERVAL BETWEEN ONSET AND DEATH 20 yrs approx					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1963 to June 15, 1967 , that (I) (we) last saw the deceased alive on June 15, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Isaac H Pendleton M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) 650.H PENDLETON				23D. ADDRESS 1723 Daniel Hele Ave Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-19-67		24C. NAME OF CEMETERY or CREMATORY Carver Mem. Park	
24D. LOCATION (City, town, or county) Laurel, Maryland		24E. FUNERAL DIRECTOR Arlington S. Phillips		24F. ADDRESS 1727 N. Monroe Street	
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Arlington S. Phillips	

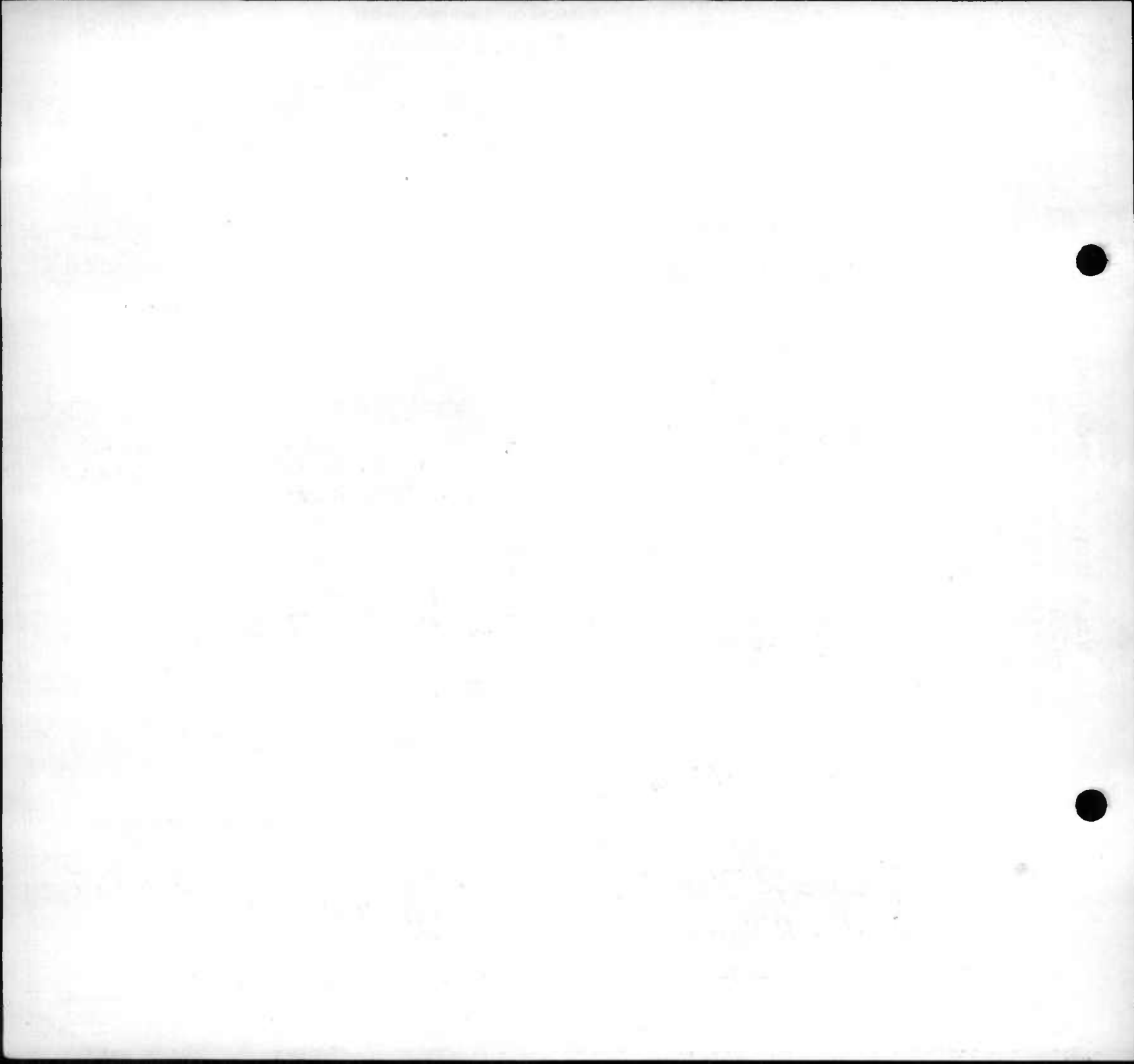
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5925 CERTIFICATE OF DEATH					Registered No. 67 5925				
BIRTH NO. M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) MARY A. DAVIS					June 18, 1967 M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 House in the Pines 5837 Belair Rd. Balto. Md. 21206					A. STATE Maryland B. COUNTY Baltimore Co.				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Essex (21)				
D. STREET ADDRESS (If rural, give location) 1626 Gail Road					9. AGE (In years last birthday) 84				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Oct. 26, 1882		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10B. KIND OF BUSINESS OR INDUSTRY Social Security Admin.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph Wiessner					14. MOTHER'S MAIDEN NAME Catherine Ulsch				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --			16. SOCIAL SECURITY NO. 218 10 6829A		17. INFORMANT ADDRESS Margaret Benson 3639 Nichol Ave. SE Wash. D.C.				
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH		
					(A) Acute Pulmonary Embolism		weeks		
					(B) Anterior Myocardial Infarction				
					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Uremia		weeks		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/10/1967 to 6/18/1967 , that (I) (we) last saw the deceased alive on 6/17/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
23A. SIGNATURE Albert B. Bradley					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/19/67		
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, MD.					23D. ADDRESS 4900 Belair Rd. Baltimore Balto., Md. 21206				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/21/67		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967			25B. NAME OF REGISTRAR Robert E. Bailey, M.D.		25C. FUNERAL DIRECTOR ADDRESS Bruzdzinski Funeral Home 1407 Eastern Ave.				

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

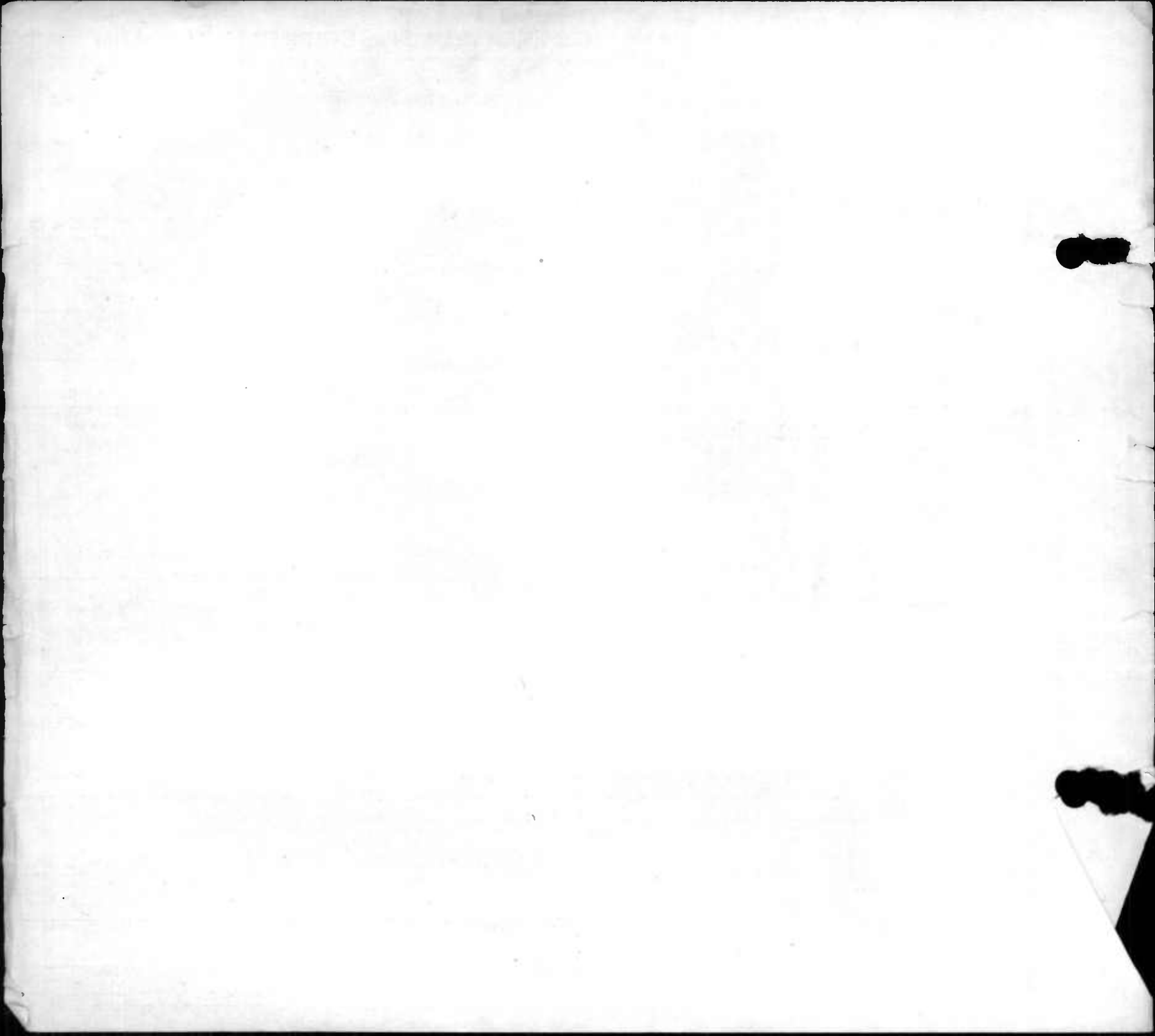
BIRTH NO. 67 5926		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5926	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ella Gough Tibbs		2. DATE AND HOUR OF DEATH 6-13-67			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 14-02			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1624 Druid Hill Avenue Baltimore, Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.			
		D. STREET ADDRESS (If rural, give location) 1624 Druid Hill Ave.			
5. SEX Female	6. RACE Negroid	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-2-93	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Tom Gough		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Edward Tibbs 1624 Druid Hill Avenue	
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of Colon and Breast (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 05 years 01 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Essential Hypertension					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 6/13/67 9:30 AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles R. Venter		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/17/67	
23C. PHYSICIAN'S NAME (Type) Charles R. Venter		23D. ADDRESS 2320 Eutaw Place Baltimore, Md 21217			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-17-67		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Nelson Funeral Home 1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5927	
BIRTH NO. 67 5927		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Viola Smith</i>		2. DATE AND HOUR OF DEATH <i>6-18-67 12:45 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>15-02</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Meary Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>1506 Appleton Street</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Wid.</i>	8. DATE OF BIRTH <i>4-6-81</i>	9. AGE (In years last birthday) <i>86</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Jesse Harris</i>		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Lonnie Penny 6212 Reerless Avenue</i>	
18. <i>260 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Nonketotic hyperglycemic coma, lactic acidosis</i>		CAUSE OF DEATH (A) <i>Gram negative Septicemia</i> DUE TO (B) <i>Sanguine foot</i> DUE TO (C) <i>Diabetes mellitus</i> <i>Nonketotic hyperglycemic coma, lactic acidosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>18 hours</i> <i>4-5 months</i> <i>Many years</i> <i>18 hours</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-18-67 11:45 am</i> to <i>6-18-67 12:45 pm</i> that (I) (we) last saw the deceased alive on <i>6-18-67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>B. V. Chalam</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6-18-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>B. V. CHALAM, M.D.</i>		23D. ADDRESS <i>Meary Hospital, Balt Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-18-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Arbutus Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 20 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Seibert</i>		25C. FUNERAL DIRECTOR <i>Nelson Funeral Home 1348 Calhoun St.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5928	
67 5928 CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) MATTHEW James				6/16/67 9:50 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND B. COUNTY		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 932 ABBOTT COURT		
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 7-9-87	9. AGE (In years lost birthday) 79	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md	
13. FATHER'S NAME James		14. MOTHER'S MAIDEN NAME Eliza		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-07-4094		17. INFORMANT ADDRESS Mrs Addie Hines 2742 Riggs Ave	
18. 4428 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral vascular Accident 8 days			INTERVAL BETWEEN ONSET AND DEATH 8 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCUD			years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Nephrosclerosis			years		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/8 1967 to 6/16 1967 . that (I) (we) last saw the deceased alive on 6/16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Clarence H. Brown III				23B. DATE SIGNED 6/16/67	
23C. PHYSICIAN'S NAME (Type) CLARENCE H. BROWN III				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/20/67		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetry	
				24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave	

6/10/17

6/10/17

Control vascular content & temp

ASCVD

Myocardial infarction

years
years

No

6/10/17

6/10/17

6/10/17

6/10/17

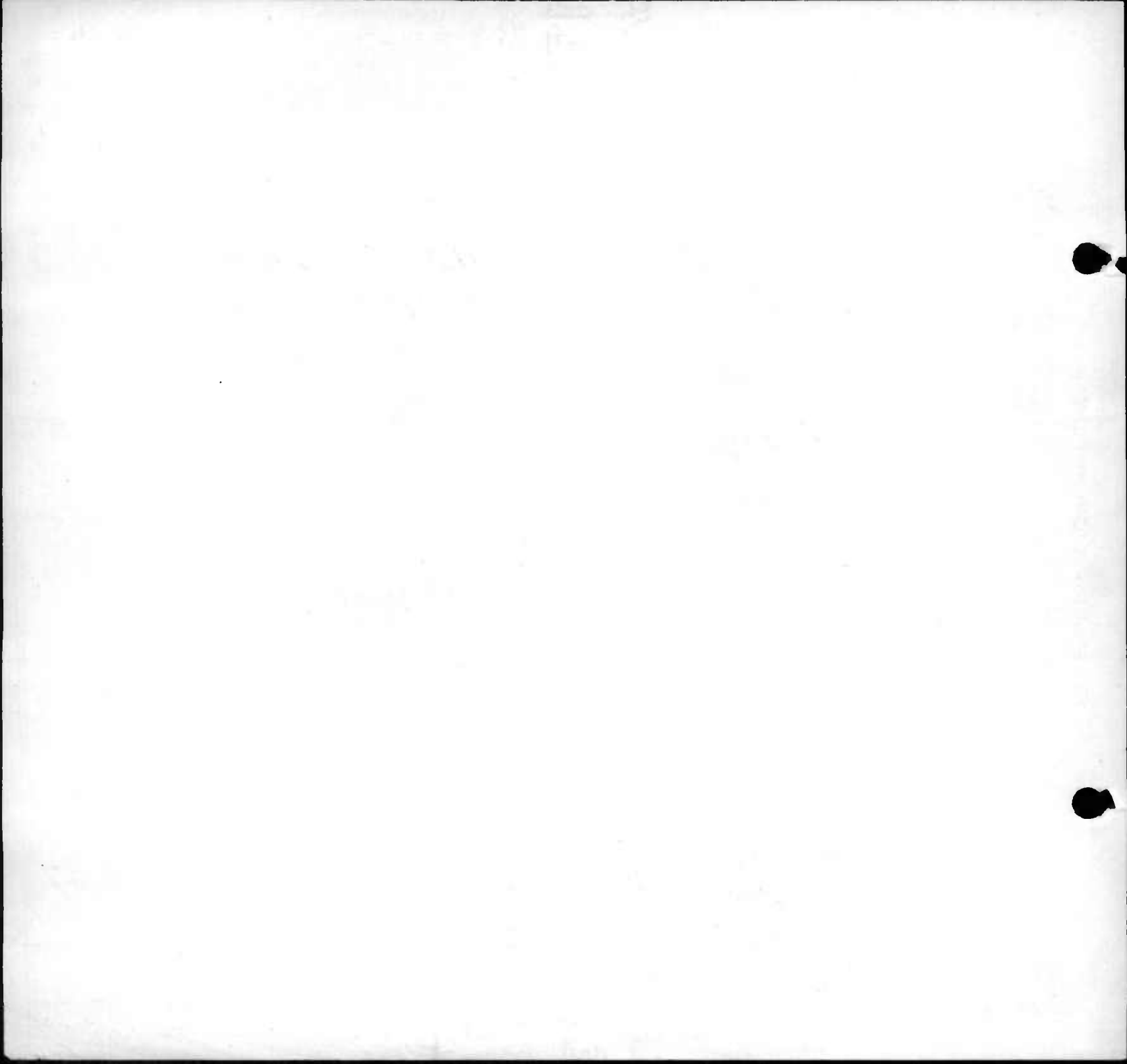
Myocardial infarction

x

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 5929 BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5929	
BIRTH NO.				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) GERTRUDE CHAVES			2. DATE AND HOUR OF DEATH 6-18-67 6:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSP BALTO. MD			A. STATE Maryland B. COUNTY 19-01		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 310 Carey St		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 11-25-06	9. AGE (In years last birthday) 60	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Queens, N.Y.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS Hospital Chart	
18. 332 X 14260 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Aspiration Pneumonia			INTERVAL BETWEEN ONSET AND DEATH Days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Thrombosis			Days to Weeks		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Coronary Heart Failure Diabetes Mellitus			Yrs.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that he (this hospital) attended the deceased from 6-8 19 67 to 6-18 19 67 , that he (we) last saw the deceased alive on 6-18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.					
23A. SIGNATURE William R. Law M.D.				23B. DATE SIGNED 6-18-67	
23C. PHYSICIAN'S NAME (Type) WILLIAM R. LAW				23D. ADDRESS UNIVERSITY HOSPITAL BALTO. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE JUN 20 1967		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967			
25B. NAME OF REGISTRAR W. E. Taylor		25C. FUNERAL DIRECTOR L. M. C. C. C.		25D. ADDRESS 2302 W North Ave Balt 16 Md	



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JESSIE

CRUTCHFIELD

2. DATE AND HOUR PRONOUNCED DEAD

June 15, 1967

8:00 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 702 E. Chase Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

702 E. Chase Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

2-26-36

9. AGE (In years
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

ALA.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

WATSON

ROXANS

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Edward L. Crutchfield 702 E. CHASE ST

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Cirrhosis of Liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

6/16/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

6/20/67

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

A. D. County, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 20 1967

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

Joseph J. Locks, Jr. 1304 N. Central Ave

ADDRESS

2-22-32

ALB.

Watson
Roxbury

No.

Rev. E. C. Watson

W. B. Watson

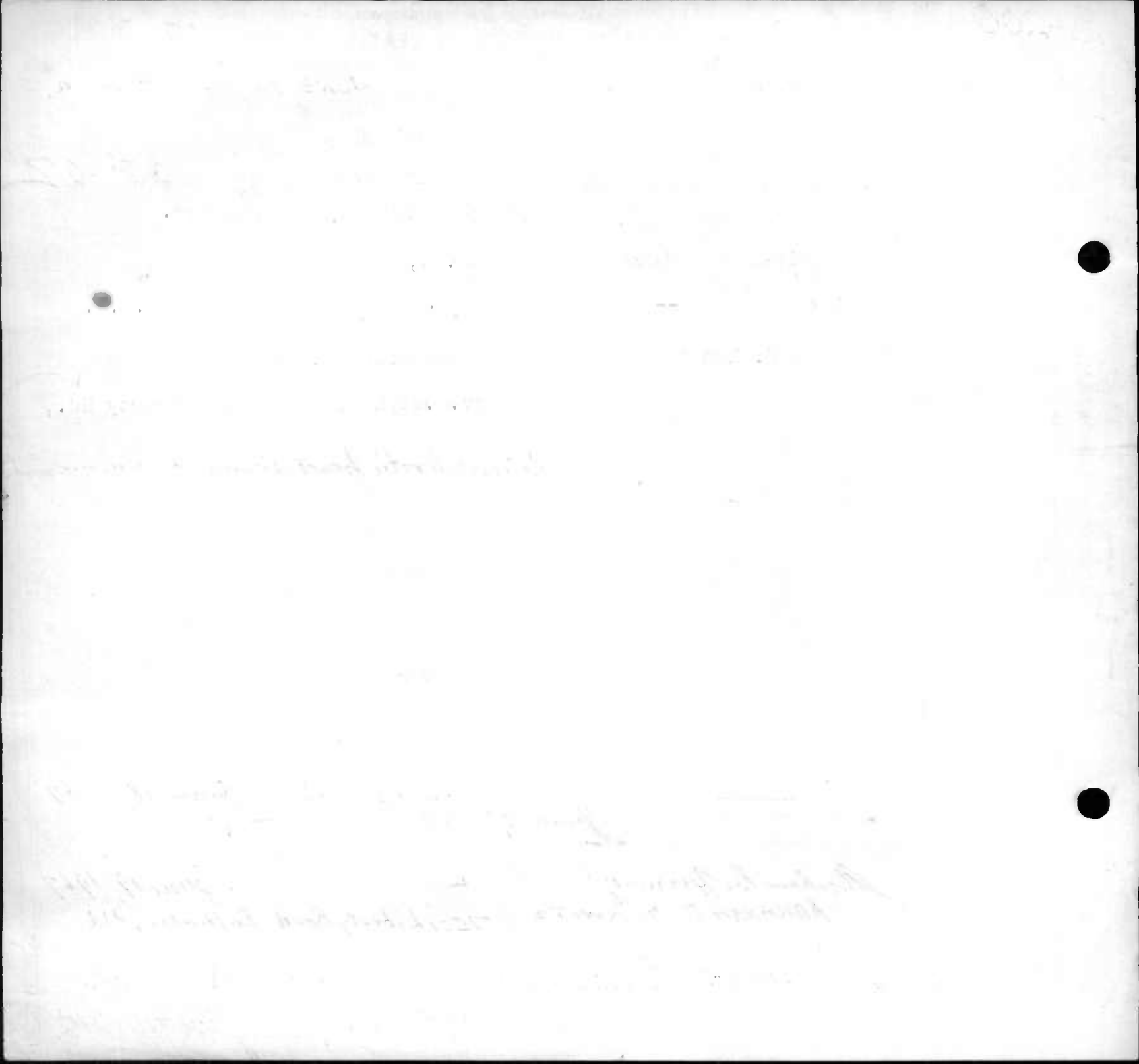
Watson & Co.

Watson & Co.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5931</u>	
BIRTH NO. <u>67 5931</u>				CERTIFICATE OF DEATH	
M.E. CASE NO. <u>67 5931</u>					
1. NAME OF DECEASED (Type or Print) <u>SARAH BESSEE</u>			2. DATE AND HOUR OF DEATH <u>JUNE 18, 1967 4:00 a. m.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Mount Convalescent Home</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>28-02</u> D. STREET ADDRESS (If rural, give location) <u>5005 Liberty Heights Ave.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 14, 1875</u>	9. AGE (In years last birthday) <u>91</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Benjamin F. Lee</u>			14. MOTHER'S MAIDEN NAME <u>Catherine A. Bond</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>Rev. Joseph C. Wood 8336 Liberty Rd.,</u>		
17. INFORMANT <u>Rev. Joseph C. Wood 8336 Liberty Rd.,</u>			ADDRESS		
18. <u>730.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic heart disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>unknown</u>			CAUSE OF DEATH (A) <u>Arteriosclerotic heart disease</u> (B) <u>unknown</u> (C) <u>unknown</u>		
19. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <u>no</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 13, 1966</u> to <u>June 18, 1967</u> , that (I) <u>was</u> lost saw the deceased alive on <u>June 17, 1967</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>Abraham B. Hurwitz</u>			23B. DATE SIGNED <u>June 19, 1967</u>		
23C. PHYSICIAN'S NAME (Type) <u>ABRAHAM B. HURWITZ</u>			23D. ADDRESS <u>7501 Liberty Road, Baltimore, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-20-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>					
25A. DATE DEATH BY HEALTH DEPT. <u>JUN 20 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Siskind</u>		25C. FUNERAL DIRECTOR <u>Robert E. Siskind</u>	
25D. ADDRESS <u>3201 N. North Ave</u>					



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67 5932 BALTIMORE CITY HEALTH DEPARTMENT 67 5932

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) KENNETH C. LINCOLN

2. DATE AND HOUR PRONOUNCED DEAD June 17, 1967 11:12 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 Pier #7, Lancaster - President Sts.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH June 13 - 1968 9. AGE (In years last birthday) 9

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James A. Lincoln 14. MOTHER'S MAIDEN NAME Beulah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO.

17. INFORMANT James P. Lincol Address

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Drowning (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) water 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Pier #7 - Lancaster & President Sts.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 6-17-67 10:45 A.M. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? Slipped and fell off pier into water

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED June 17, 1967

EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 6-21-67 23C. NAME OF CEMETERY or CREMATORY Buthut Nat Cent 23D. LOCATION (City, town, or county) (State) Buthut Md

24A. DATE REC'D BY HEALTH DEPT. JUN 20 1967 24B. NAME OF REGISTRAR Robert E. Farley 24C. FUNERAL DIRECTOR Charles D. Wilson 24D. ADDRESS

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5933	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 5933 CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Jeanette Boston</i>			2. DATE AND HOUR OF DEATH <i>6/17/67 9:40 P. M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>33 THE JOHNS HOPKINS HOSPITAL</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND, ANNE ARUNDEL Co B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE D. STREET ADDRESS (If rural, give location) 1000 CRAIN HIGHWAY		
5. SEX FEMALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8-10-01	9. AGE (In years lost birthday) 65	10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME JAMES JONES			14. MOTHER'S MAIDEN NAME ANNA SNOWDEN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NU</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11-260X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Mesenteric Vein Thrombosis - 5 days</i> DUE TO (B) <i>Myocardial Infarction</i> DUE TO (C) <i>Congestive Heart Failure + Diabetes Mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Indeterminate Age</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>6/15/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Mesenteric Vein Thrombosis</i>		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/15</i> 19 <i>67</i> to <i>6/17</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6/17</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date <i>6/17</i> 19 <i>67</i> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Fremont P. Wirth, Jr.</i> M.D.				23B. DATE SIGNED <i>6/17/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Fremont P. Wirth, Jr.</i> M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>6-2267 Burial</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt Calvary</i>		24D. LOCATION (City, town, or county) (State) <i>Brooklyn Ind</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 20 1967</i>		25B. NAME OF REGISTRAR <i>Chas. E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Chas. E. Wilson 1000 B. Mount St</i>	

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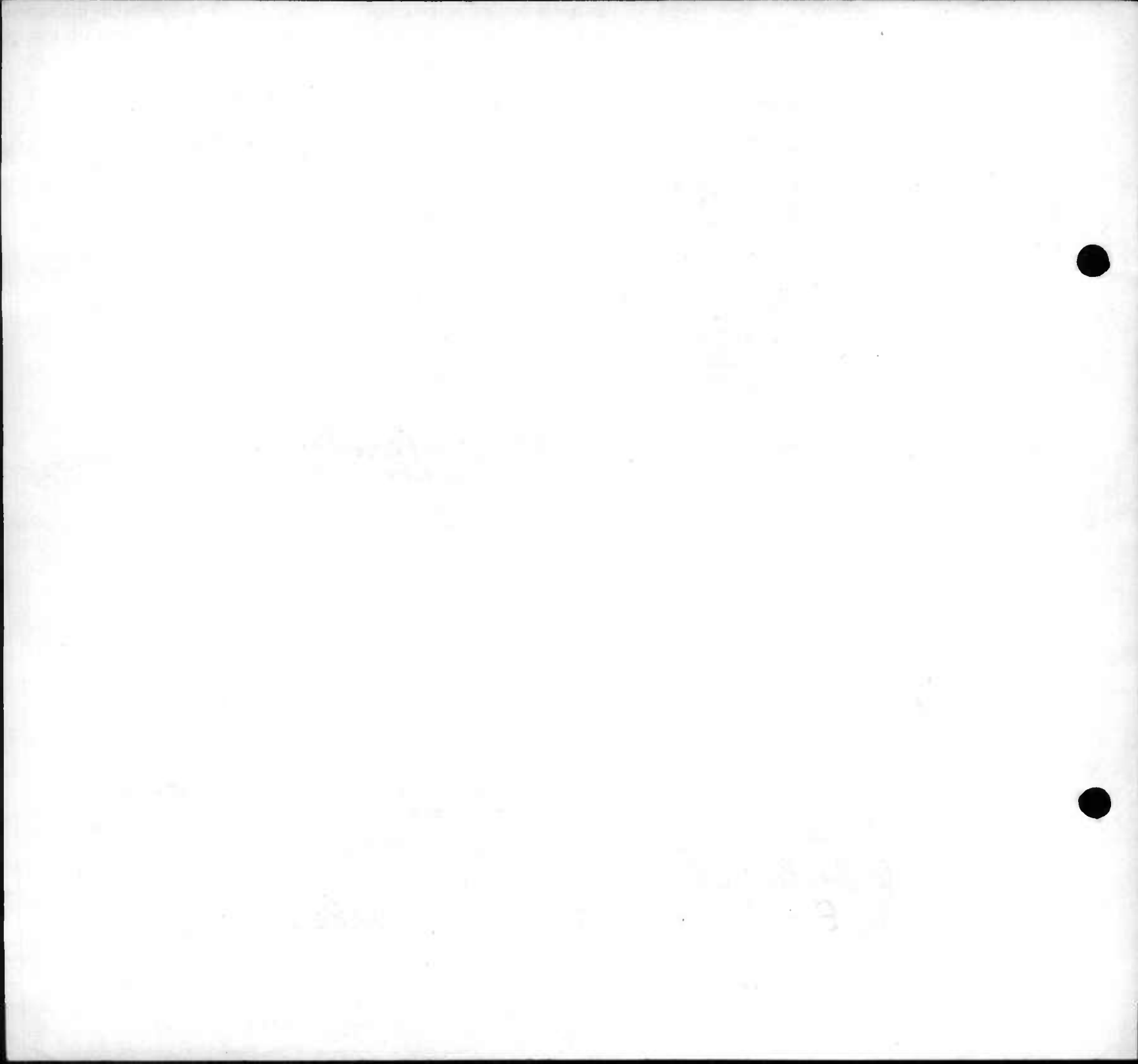
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH														
BIRTH NO. 67 5934		Registered No. 67 5934												
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William Hackett				2. DATE AND HOUR OF DEATH June 2 1967 M.								
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2802 W. Winchester St.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore									
					D. STREET ADDRESS (If rural, give location) 2802 Winchester St									
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 12-11-1888	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days Hours Min.									
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Va. Richmond		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Daniel Beach			14. MOTHER'S MAIDEN NAME Peggy Beach											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Minie Scott				ADDRESS Same					
I 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 4-22-11 Atherosclerotic cordis vascular disease					CAUSE OF DEATH Interval between onset and death undetermined									
										ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
										II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)										
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?										
22. I certify that (I) (this hospital) attended the deceased from 5-10-67 19 67 to 5-1-1967 , that (I) (we) last saw the deceased alive on 5-1-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Dr. Barbu Calin					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED							
23C. PHYSICIAN'S NAME (Type) DR. BARBU CALIN					23D. ADDRESS 831 Poplar Grove St.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-4-67		24C. NAME of CEMETERY or CREMATORY Cape Charles Cmt		24D. LOCATION (City, town, or county) (State) Cd								
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Gray Samuel Horne		ADDRESS Va.								

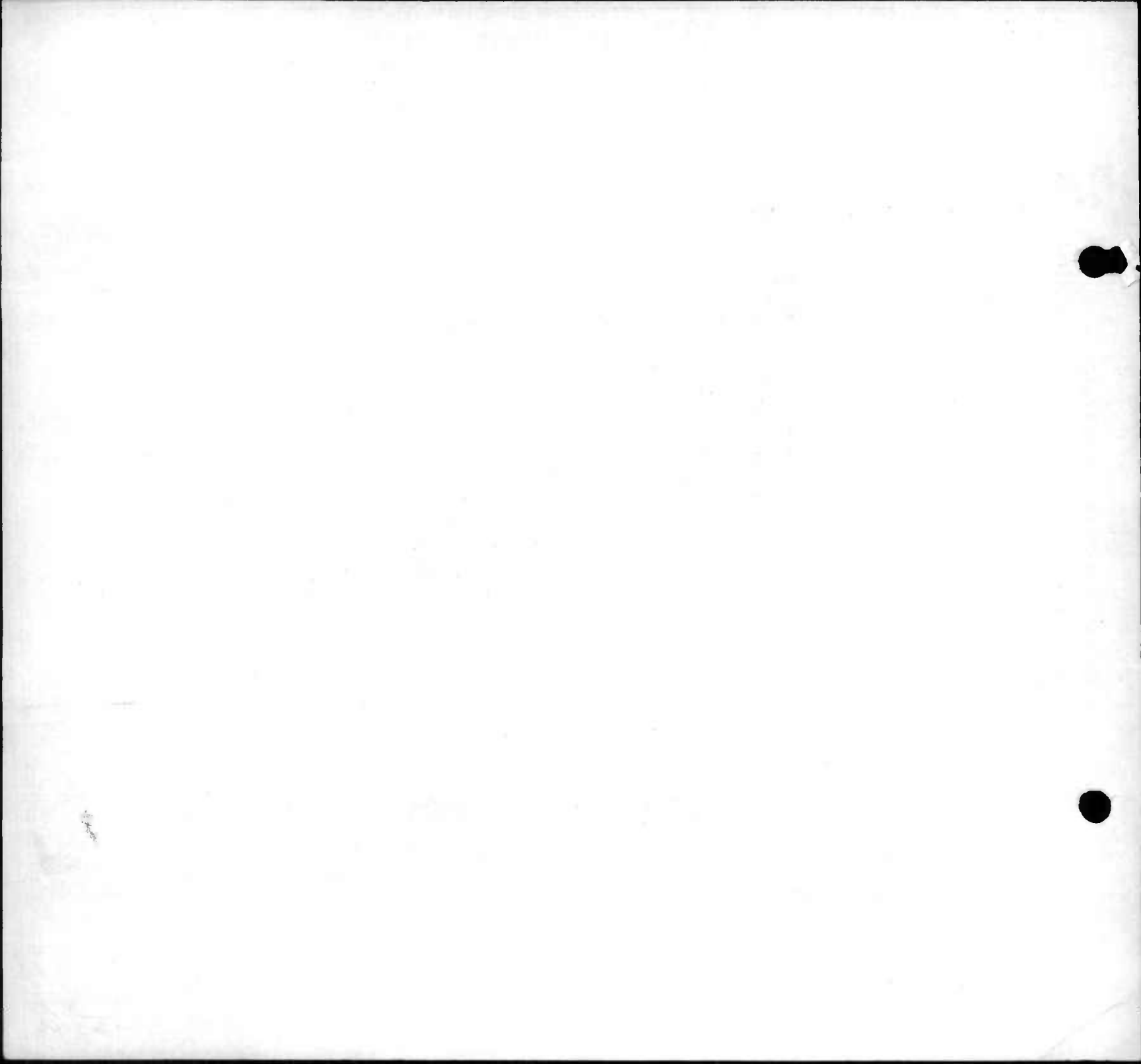


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released as Non Med by Medical Examiners Ofc. per Mr. Swoboda MEDICAL CERTIFICATION

BIRTH NO. <u>66-22826 67</u> <u>5935</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. <u>67</u> <u>5935</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Suzette Johnson</u>		2. DATE AND HOUR OF DEATH <u>6-19-67</u> <u>8:15 A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>7-05</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1825 Ashland Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>		8. DATE OF BIRTH <u>10-25-66</u>	9. AGE (In years last birthday) <u>25</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>Charles Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Pearlie Bernet</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>N</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charles Johnson</u> ADDRESS <u>same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Anoxia 20 to 20 to thrombosis of both middle cerebral arteries</u> INTERVAL BETWEEN ONSET AND DEATH <u>5</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) CHD - Thrombosis of Fallopian <u>Imperforate appendix, Rinal disease, etc?</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>18 June</u> 19 <u>67</u> to <u>19 June</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>18 June</u> 19 <u>67</u> and that is (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles Johnson</u> M.D.				23B. DATE SIGNED <u>19 June 67</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-21-67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Int. Catholic Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>		24E. NAME OF REGISTRAR <u>Robert E. Taylor</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 20 1967</u>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <u>Chas. O. Wilson</u> ADDRESS <u>10013 Canterbury Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 5936		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		67 5936	
CERTIFICATE OF DEATH									
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		Franklin A. Owens SA		2. DATE AND HOUR OF DEATH 6/6/67 6:25 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY		Md.		13-03	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore			
33 Johns Hopkins				D. STREET ADDRESS (If rural, give location)		1214 Whitelock St			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
M	N	Married	10-06-89	77	Retired	USA	USA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Ancher B Owens				Emma Edwards					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
M						Emma E. Owens		Lana	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH	
CUA				Probable Sepsis from pneumonia				3 1/2 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.								2 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				YES		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from May 27 1967 to June 16 1967, that (I) (we) last saw the deceased alive on 6/16 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Robb E. Moses M.D.				6/16/67					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Robb E. Moses				Johns Hopkins					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		6-21-67		Arbiter's Cut		Lana		Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUN 20 1967		Robb E. Moses		Choy Wilson		1000 Brentwood			

10-00-80

John H. Hines

M. N. M. N. M. N.

10-00-80
1214 Whitehead St
Baltimore
Md.

2-20-80
2-20-80

604
Cable News
from Baltimore

Yes No

10-00-80
10-00-80
10-00-80

John H. Hines
Robt E. Moses
10-00-80

W 252

67 5937

BALTIMORE CITY HEALTH DEPARTMENT

67 5937

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JACQUELINE WASHINGTON

2. DATE AND HOUR PRONOUNCED DEAD

6-13-67

6:45 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore
1930 E. Eager Street 21205

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Aug 4-1955

9. AGE (In years
last birthday)

11

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

School girl

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY

USA

13. FATHER'S NAME

Milton Washington

14. MOTHER'S MAIDEN NAME

Bessie Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Wilhel Wolfork

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Intracerebral hemorrhage - (cerebellum)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Rupture of vascular malformation
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-13-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-17-67

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cmt

23D. LOCATION (City, town, or county)

Brooklyn Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 20 1967

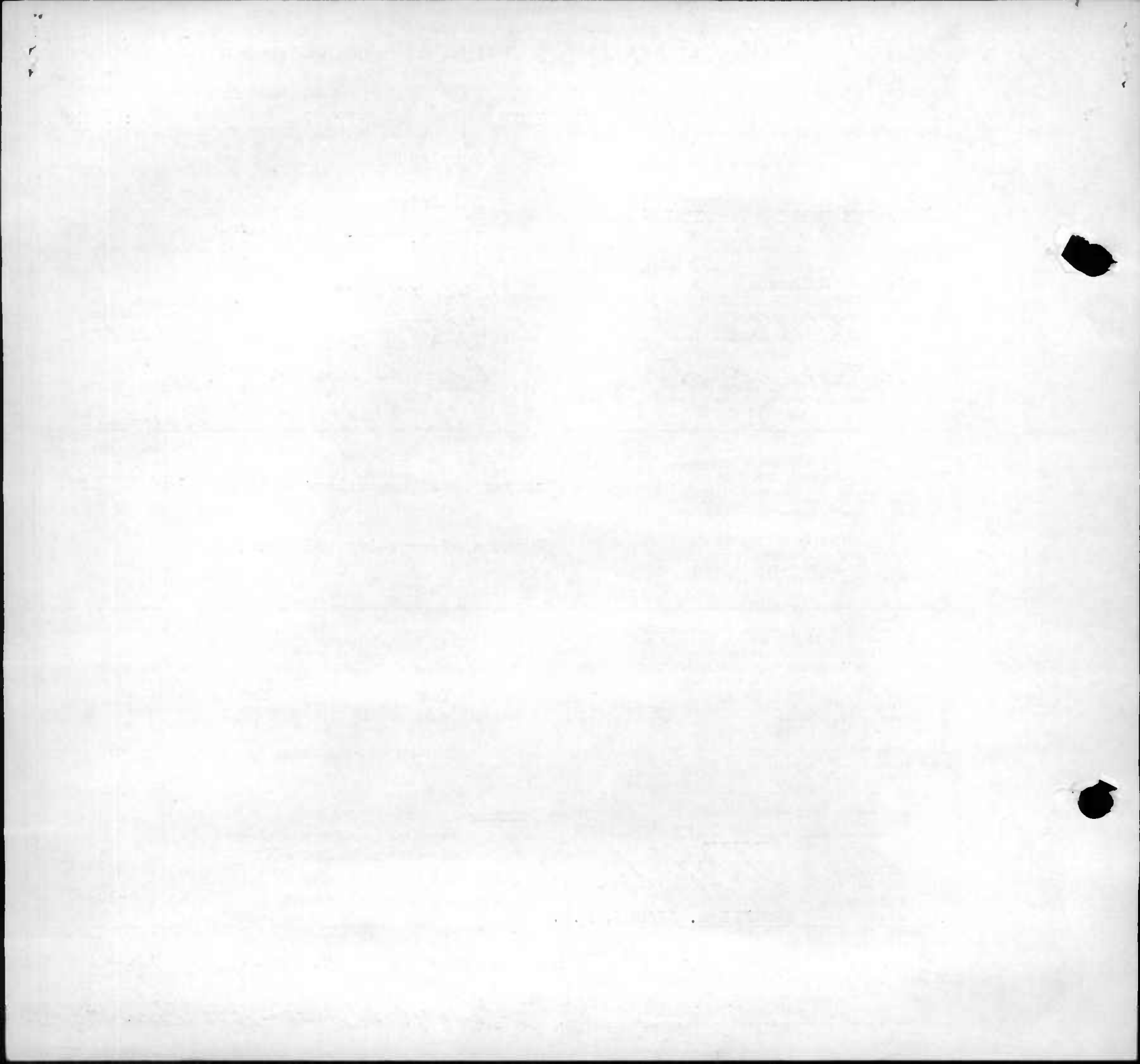
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Roy W. Wilson 1000 Blandford

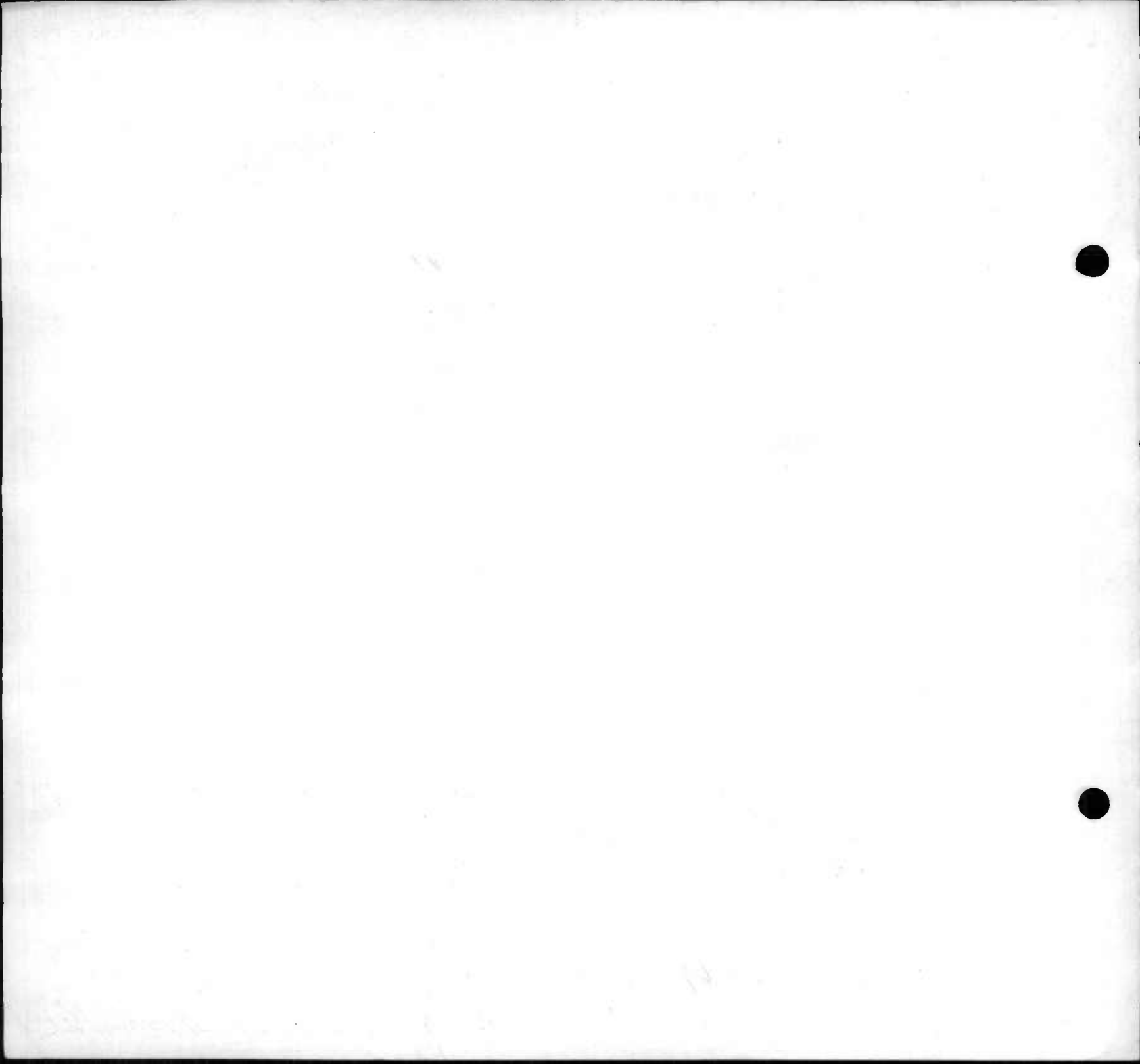
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

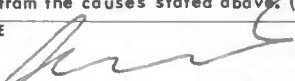
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

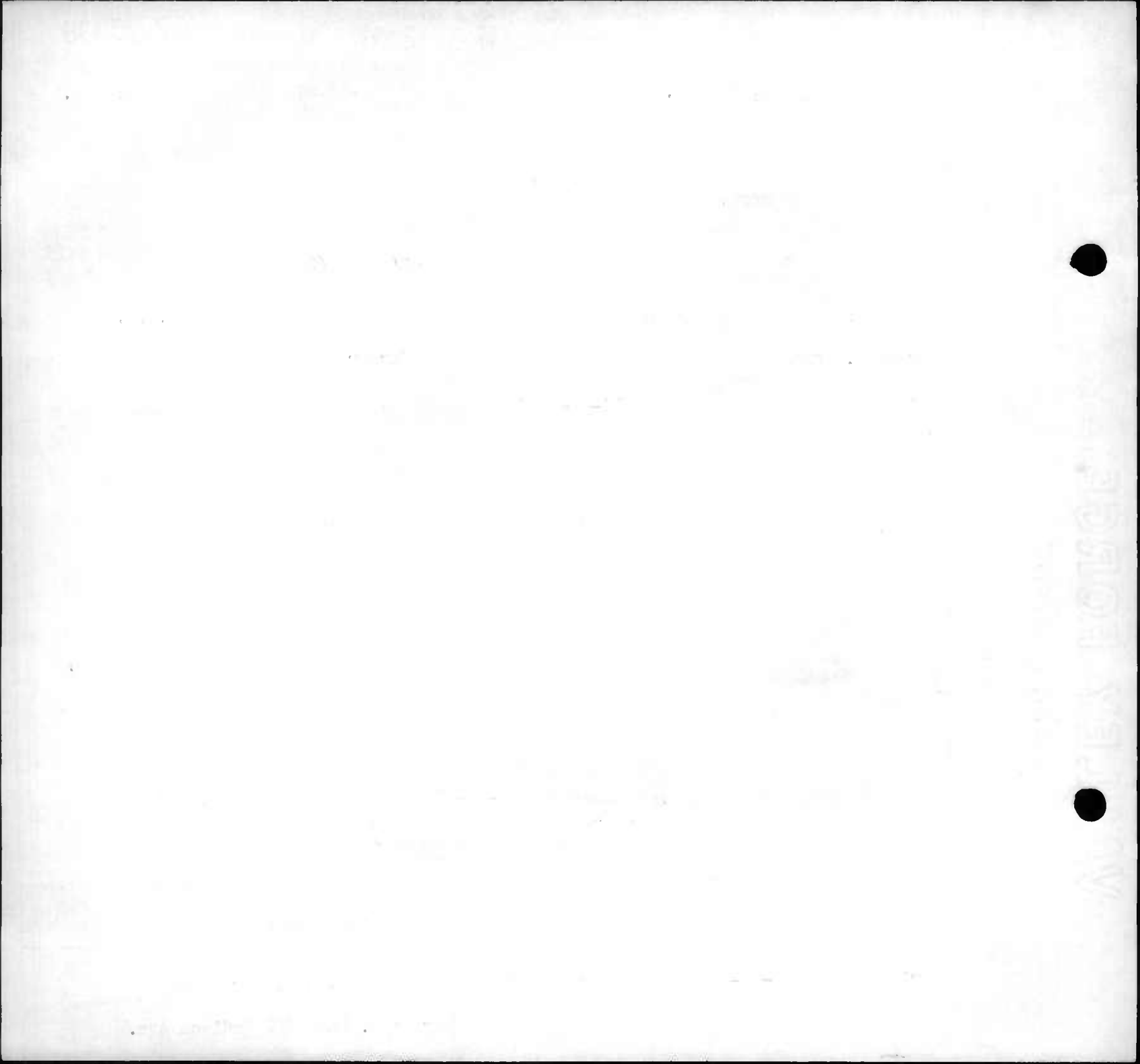
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 67 5938	
BIRTH NO. 67 5938		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) James H. Mattheus		2. DATE AND HOUR OF DEATH June 15 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2007			
FULL NAME OF HOSPITAL OR INSTITUTION 414 Normandy ave.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 414 Normandy ave. NORMANDY			
5. SEX Male	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH May 11-1886	9. AGE (In years, last birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) murder		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Charlotte Co Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dennis Mattheus				14. MOTHER'S MAIDEN NAME Robert			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Elizabeth Mattheus		ADDRESS Same	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO Acute Myocardial Infarct		1/2 hrs	
				(B) DUE TO ASHD with comp failure		5 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/15-1967 to 6/15 1967 , that (I) (we) last saw the deceased alive on 6/15 1967 and that (my) (our) apnial death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leon E. Kessel				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/19/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 3501 S. Paul St, Balt MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-20-67		24C. NAME OF CEMETERY or CREMATORY Cover Cent		24D. LOCATION (City, town, or county) (State) Lanual Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Elmer Wilson		ADDRESS 1000 Brantley Ave	



FUNERAL DIRECTOR: IMPORTANT

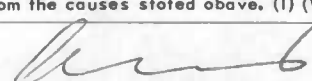
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

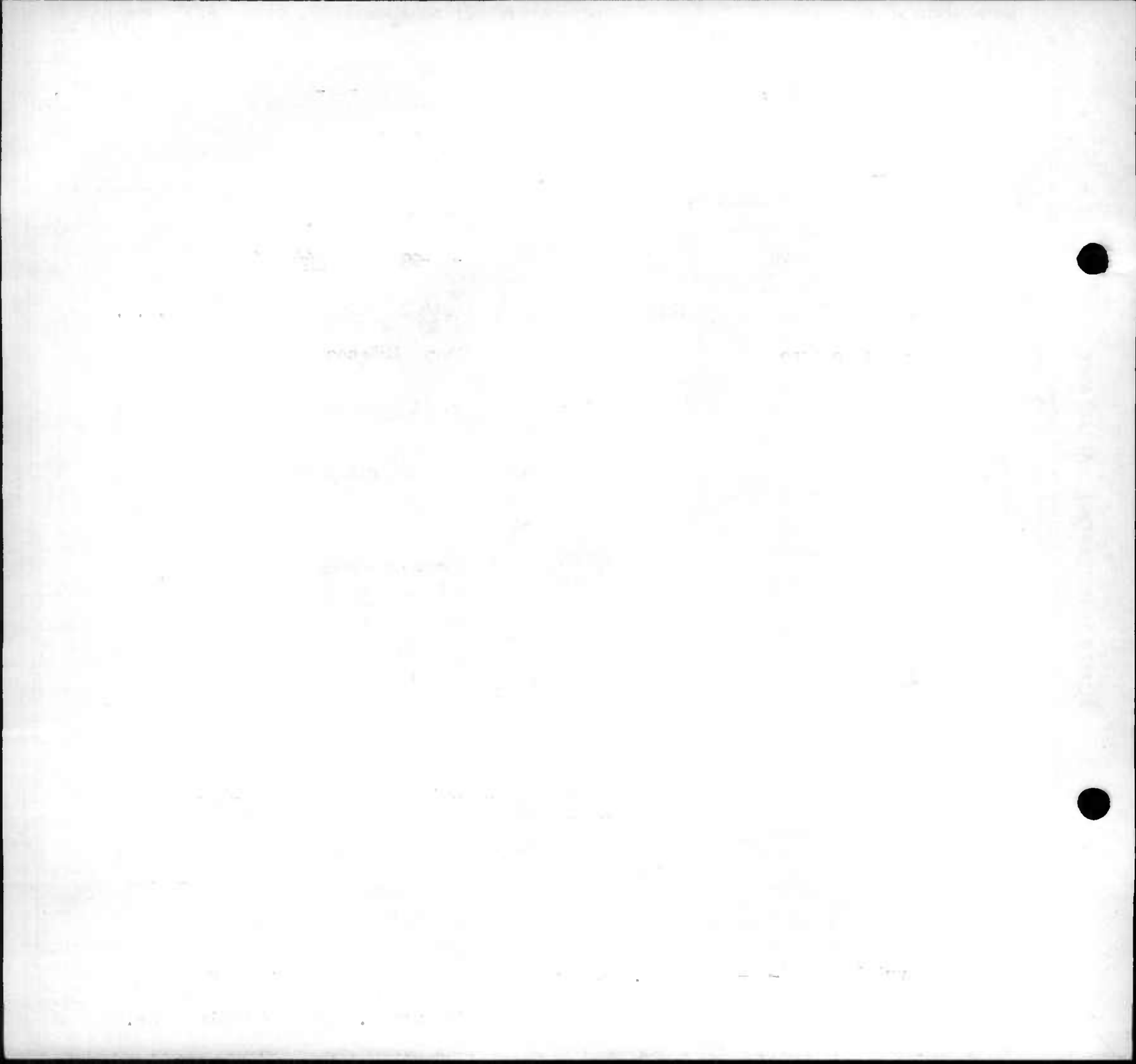
BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 67 5939		CERTIFICATE OF DEATH				Registered No. 67 5939				
1. NAME OF DECEASED (Type or Print) Wilson, Mary E.						2. DATE AND HOUR OF DEATH 6-18-67 6:05 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital, Inc. Baltimore, Maryland 21217						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1601 Bruce Street				
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 12-12-04	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frank A. Lomax				14. MOTHER'S MAIDEN NAME Emma Garner						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214-14-9584		17. INFORMANT Mary Jordan (Daughter)				ADDRESS 1721 Baker Street	
18. CAUSE OF DEATH 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Congestive Heart Failure DUE TO (B) Myocardial Infarction DUE TO (C)						INTERVAL BETWEEN ONSET AND DEATH One Day				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6-18-67 19 to 6-18-67 19, that (I) (we) last saw the deceased alive on 6-18-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE  M.D. ATA AMINI						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-18-67		
23C. PHYSICIAN'S NAME (Type) ATA AMINI			23D. ADDRESS M.D. 1415 Division Street							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-22-67		24C. NAME OF CEMETERY OR CREMATORY Carver Memorial Park		24D. LOCATION (City, town, or county) (State) Laurel, Maryland				
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967			25B. NAME OF REGISTRAR Robert E. J. [illegible]		25C. FUNERAL DIRECTOR Charles R. Law					
ADDRESS 802 Madison Ave.										



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

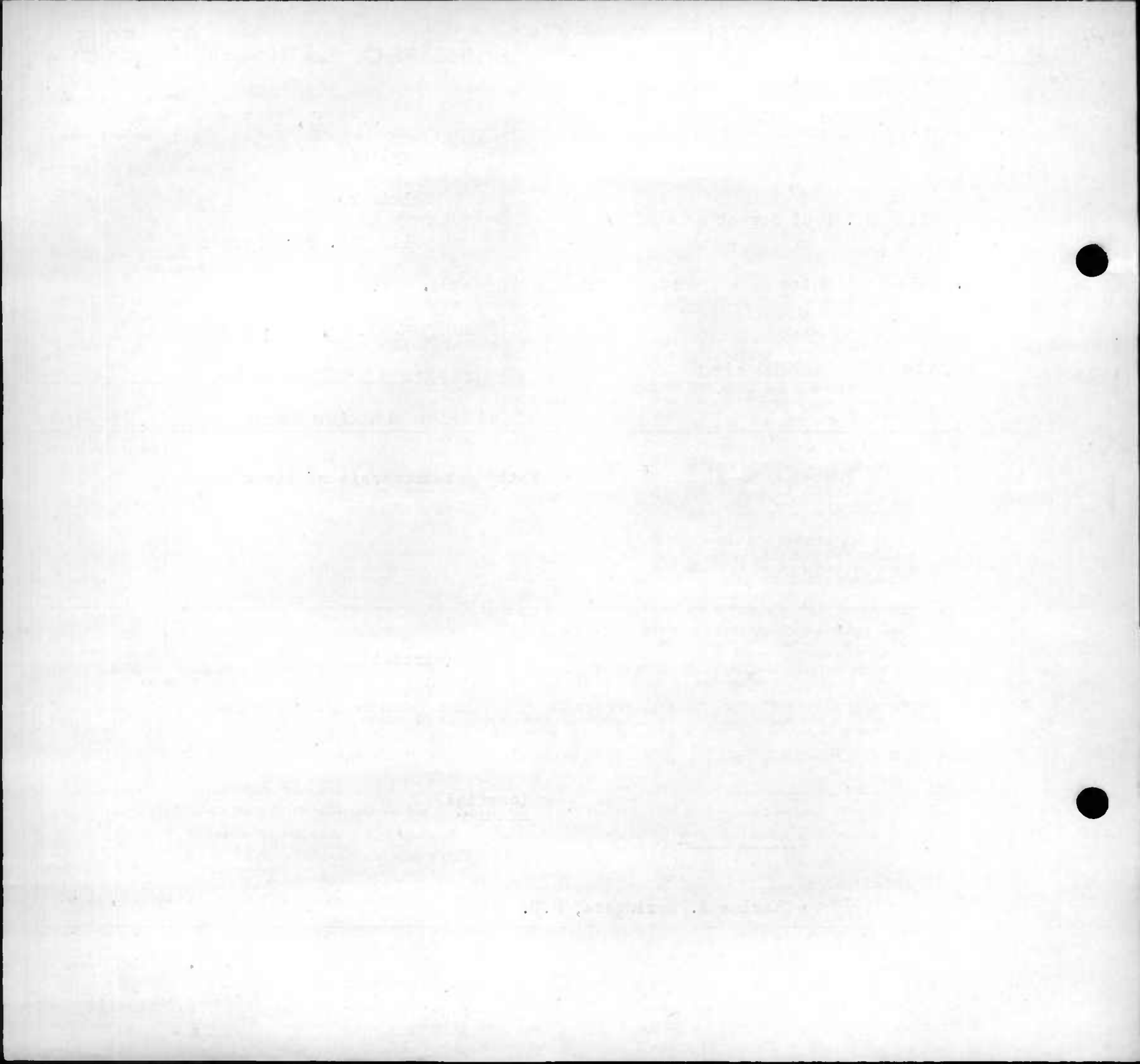
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5940</u>	
BIRTH NO. <u>67 5940</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>6-17-67</u> <u>12:30 P.</u> M.			
1. NAME OF DECEASED (Type or Print) <u>Horton, Addie</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-11</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>39 Provident Hospital, Inc.</u> <u>Baltimore, Maryland 21217</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3615 Wabash Ave.</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4-14-99</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>France McKesson</u>		14. MOTHER'S MAIDEN NAME <u>Mary McKeseon</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>240-05-2090</u>		17. INFORMANT ADDRESS <u>Addell Rokefort (Daughter) Same</u>	
18. <u>450.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Generalized arterie & atherosclerosis</u> DUE TO <u>Bronchopneumonia</u> DUE TO <u>Marked pulmonary edema</u>		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-14-67</u> 19 to <u>6-17-67</u> 19, that (I) (we) last saw the deceased alive on <u>6-17-67</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  M.D. <u>Amini</u>				23B. DATE SIGNED <u>6-19-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Amini</u>		23D. ADDRESS M.D. <u>1415 Division Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-21-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Calvary</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 20 1967</u>			
25B. NAME OF REGISTRAR <u>Charles R. Law</u>		25C. FUNERAL DIRECTOR ADDRESS <u>802 Madison Ave.</u>			



H. 252

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) HOMER DALE HAWKINS		2. DATE AND HOUR PRONOUNCED DEAD June 17, 1967 6:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3113 St. Paul Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3113 St. Paul Street	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH Jan. 13, 1913
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 53
11. BIRTHPLACE (State or foreign country) Mannington, W. Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME late William Hawkins		14. MOTHER'S MAIDEN NAME Georgia Virginia White	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS William Hawkins Mannington W. Virginia
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver (A) DUE TO II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (partial)			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED June 17, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE June 26 '67	23C. NAME OF CEMETERY or CREMATORY Mannington Cemetery	23D. LOCATION (City, town, or county) (State) Mannington, W. Virginia
24A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		24B. NAME OF REGISTRAR Charles S. Springate	24C. FUNERAL DIRECTOR ADDRESS Howard County Funeral Home Harry Witzke Ellicott City Md.

19670005951



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. <u>67 5942</u>	
BIRTH NO. <u>67-11971 67 5942</u>											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL SARACINO</u>										2. DATE AND HOUR OF DEATH <u>JUNE 18, 1967</u> <u>7:00 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 SAINT AGNES HOSPITAL</u> <u>WILKENS & CATON AVENUES</u> <u>BALTIMORE, MARYLAND 21229</u>					A. STATE <u>MD.</u>					B. COUNTY <u>ANNE ARUNDEL COUNTY</u>	
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>GLENBURNIE, MARYLAND</u> <u>52-00</u>	
										D. STREET ADDRESS (If rural, give location) <u>5806 RITCHIE STREET</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>INFANT</u>		8. DATE OF BIRTH <u>06/18/67</u>		9. AGE (In years last birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>19 6</u>			
13. FATHER'S NAME <u>LOUIS SARACINO</u>						14. MOTHER'S MAIDEN NAME <u>JUDITH ROBINSON</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>ST. AGNES HOSP. RECORDS</u>		ADDRESS <u>WILKENS & CATON AVENUES</u>			
18. <u>776 X I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Prematurity</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that <u>X</u> (this hospital) attended the deceased from <u>(2:06AM) 6/18 1967</u> to <u>(7PM) 6/18/ 1967</u> , that <u>X</u> (we) last saw the deceased alive on <u>6/18 1967</u> and that in <u>(Xy)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) <u>XXXXX</u> view the body after death.											
23A. SIGNATURE <u>Reynaldo O. Guzman</u> M.D.										23B. DATE SIGNED <u>6/18/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. R. O. GUZMAN</u>										23D. ADDRESS <u>St Agnes Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/20/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>				24D. LOCATION <u>BALTO MD</u> (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 20 1967</u>				25B. NAME OF REGISTRAR <u>John E. [unclear]</u>				25C. FUNERAL DIRECTOR <u>Thyke F. H. 4101 Edmonson Dr</u>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5943	
67 5943				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JENKINS MARIE C.	
2. DATE AND HOUR OF DEATH 6.17.67 4.05 P. M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 21229 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1025 STAMFORD ROAD		5. SEX F. 6. RACE W. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WID.			
8. DATE OF BIRTH 1.30.02 9. AGE (In years last birthday) 65		10. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Sinnott		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT John W. Jenkins ADDRESS Rt. 32, Box 280, Peverna Pk., Md.	
18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 6 hours		19. DATE OF OPERATION 2 20. AUTOPSY (Yes or No) YES			
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		22. I certify that (I) (this hospital) attended the deceased from 6.16 to 6.17 19 67 that (I) (we) last saw the deceased alive on 6.17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Milos Radojko		23B. DATE SIGNED 6.17.67		23C. PHYSICIAN'S NAME (Type) MILOS RADOJKOVIC	
24. BURIAL CREMATION, REMOVAL (Specify) Burial		25. DATE REC'D BY HEALTH DEPT. JUN 20 1967		26. NAME OF REGISTRAR Witzke F. D.	
27. DATE OF DEATH 6/21/67		28. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		29. LOCATION (City, town, or county) (State) Baltimore, Md.	
30. DATE REC'D BY HEALTH DEPT. JUN 20 1967		31. NAME OF REGISTRAR Witzke F. D.		32. ADDRESS 4101 Edmondson Ave.	

MD 21227
Baltimore
1025 STAMFORD ROAD
1-30-62

MD

John J. Janigan
11-35, Box 2, C. Janigan, N.Y.C.

Anti-Spastic Infants

RECEIVED

O

YES

6 11 6 16 6 17

Miss KROSKOVIC
John Janigan

6 17 6 17
John Janigan

M-220

67 5944

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5944

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BOHDAN WASYL MACUK

2. DATE AND HOUR PRONOUNCED DEAD

June 16, 1967

4:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

1-02

D. STREET ADDRESS (If rural, give location)

525 South Curley Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb. 17, 1960

9. AGE (In years
last birthday)

7

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Bohdan Macuk

14. MOTHER'S MAIDEN NAME

Halyna Belan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Bohdan Macuk 525 S. Curley Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Fleet Street and Elwood Avenue

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

6-14-67

3:10 P.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by car

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 17, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-20-1967

23C. NAME of CEMETERY or CREMATORY

St. Michaels Ukranian

23D. LOCATION

(City, town, or county)

Baltimore County, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 20 1967

24B. NAME OF REGISTRAR

Robert E. Springate, M.D.

24C. FUNERAL DIRECTOR

Lilly & Zeiler Inc. 1901-07 Eastern Ave.

ADDRESS



LIBRARY FORGE

RECEIVED

U.S.

OFFICE OF THE
DIRECTOR

1944

CONFIDENTIAL

SECRET

1944

CONFIDENTIAL

SECRET

CONFIDENTIAL

1944

CONFIDENTIAL

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

67 5945

BIRTH NO.

67 5945

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EMMA A. WEIR

2. DATE AND HOUR OF DEATH

June 17, 1967

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

332 S. Lehigh Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

332 S. Lehigh Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED

Married

8. DATE OF BIRTH

March 4, 1884

9. AGE (In years
last birthday)

83

If Under 1 Yr. If Under 24 Hrs.
Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Newman

14. MOTHER'S MAIDEN NAME

Louise Olinger

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Anna Kellner 332 S. Lehigh Street

18.

422.11
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/16/67 to 6/17/67
that (I) (we) last saw the deceased alive on 6/16/67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

6/19/67

23C. PHYSICIAN'S
NAME (Type)

JULIUS H GOODMAN

M.D.

23D. ADDRESS

3400 E BALTIMORE ST

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-21-1967

24C. NAME of CEMETERY or CREMATORY

Baltimore National

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 20 1967

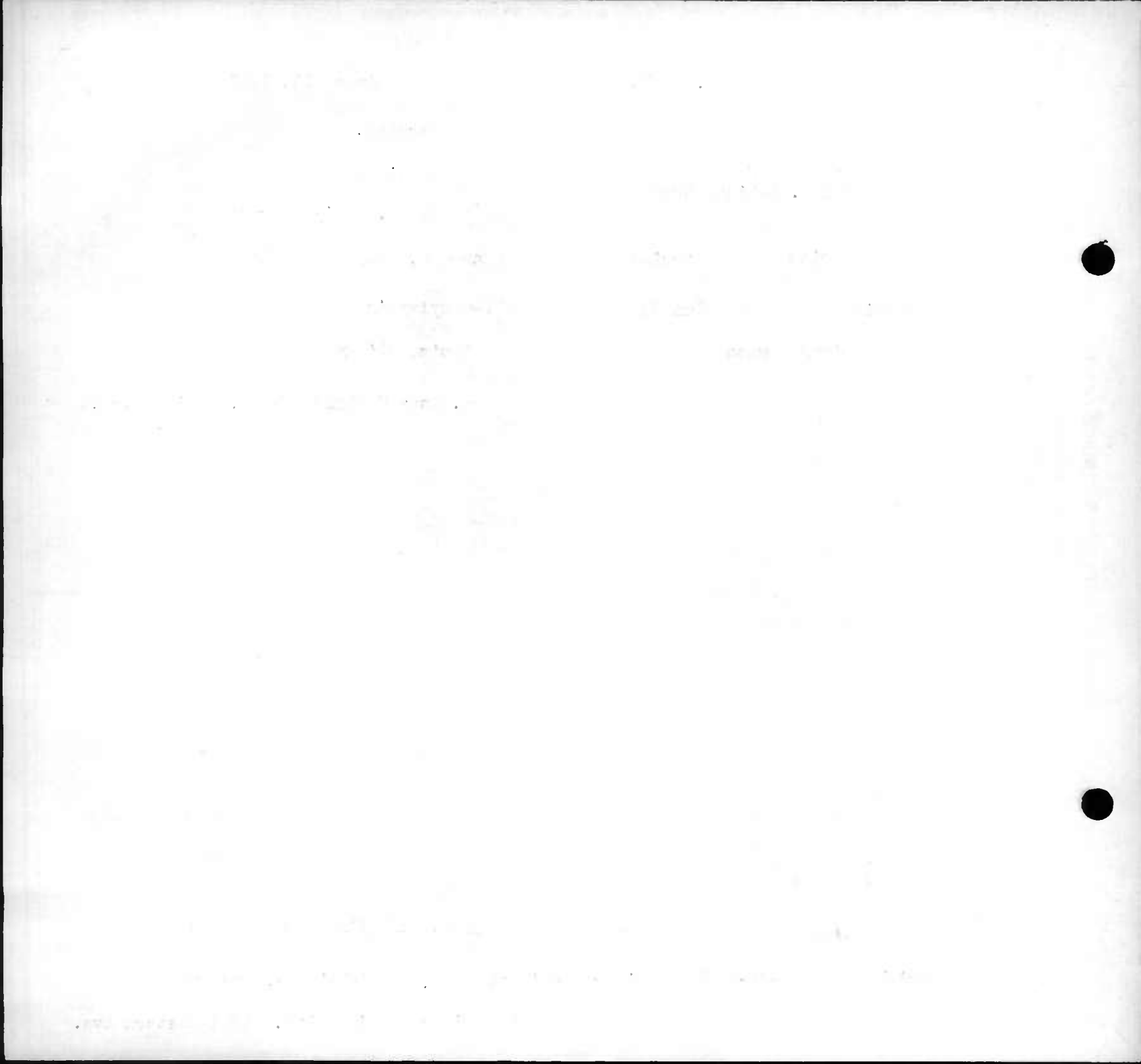
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Lilly & Zeiler Inc. 1901 Eastern Ave.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5946				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5946	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANNE PERZINSKI				2. DATE AND HOUR OF DEATH 6-19-67 7:25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home and 35 Hospital				A. STATE B. COUNTY 3141 Woodring Ave 27-05			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - 34 Md.			
				D. STREET ADDRESS (If rural, give location)			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED (specify) WIDOWED)	8. DATE OF BIRTH 11-15-85	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home maker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? Austria	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ? Sytnyk			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-92-25108		17. INFORMANT ADDRESS Harry Perzinski 400 S. Drew Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Pneumonia (B) DUE TO Diabetes Mellitus (C) Parkinson Disease		INTERVAL BETWEEN ONSET AND DEATH one week 10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-13-1967 to 6-19-1967, that (I) (we) last saw the deceased alive on 6-19-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE K.M. Anandash. M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-19-67	
23C. PHYSICIAN'S NAME (Type) K.M. ANANDASH. M.D.				23D. ADDRESS Church home & hospital. Baltimore.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-22-1967		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			

KH. HURDARAH
KH. HURDARAH

Handwritten text, possibly a signature or name, appearing as "KH. HURDARAH" in reverse.

K-260

67 5947 BALTIMORE CITY HEALTH DEPARTMENT

E7 5947

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)
GEORGE

S.

KISER

2. DATE AND HOUR PRONOUNCED DEAD

June 19, 1967

6:10 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION

ST AGNES HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

67 S. Morley Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

4-30-1944

9. AGE (In years
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Chevrolet

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James E. Kiser

14. MOTHER'S MAIDEN NAME

Thelma Keckels

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-40-3209

17. INFORMANT

Annie Kiser

ADDRESS

67 S. Morley

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Carbon Monoxide Poisoning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

garage

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

67 S. Morley Street

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

June 19, '67 5:30

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

asphyxia self

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/19/67

23A. BURIAL CREMATION
REMOVAL (Specify)

BURIAL

23B. DATE

6/22/67

23C. NAME OF CEMETERY or CREMATORY

ARbutus

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

24A. DATE RECEIVED BY HEALTH DEPT.

JUN 20 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

MORTON + DyeTT

ADDRESS

1701 LAURENS

WALLACE ROSEN
PROJECT
CONTENT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5948		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5948	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CHAMBERLAIN, WILLARD		2. DATE AND HOUR OF DEATH JUNE 16, 1967 1:40 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 915 NORTH CAREY STREET			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12-9-92	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) JAMAICA, VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME HORACE CHAMBERLAIN		14. MOTHER'S MAIDEN NAME EMMA BIRD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 6/19/18-3/12/19		16. SOCIAL SECURITY NO. 218-07-47-20A		17. INFORMANT VETERANS HOSPITAL RECORDS ADDRESS 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218	
18. 490X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bilateral pneumonia DUE TO (A) Bilateral pneumonia (B) DUE TO (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that X (this hospital) attended the deceased from JUNE 16, 1967 to JUNE 16, 1967 , that we last saw the deceased alive on JUNE 16, 1967 and that in our opinion death occurred on the date and hour and from the causes stated above. X (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE Perry G. Austin, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. X		23B. DATE SIGNED 6/19/67	
23C. PHYSICIAN'S NAME (Type) PERRY G. AUSTIN, JR.		23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Boulevard, Balto., Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/22/67		24C. NAME OF CEMETERY OR CREMATORY BALTO. NAT. BA HO.	
24D. LOCATION (City, town, or county) Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR MORTON D. BYETT		ADDRESS 1701 LAURENS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5949		CITY OF BALTIMORE CERTIFICATE OF DEATH		Registered No. 67 5949	
1. NAME OF DECEASED (Type or Print) Clarence Matthews			2. DATE AND HOUR OF DEATH June 18, 1967 1:45 a.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BonSecours Hospital Emergency Dept. (Not Admitted)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 20-02 D. STREET ADDRESS (If rural, give location) 2517 W. Fayette St.		
5. SEX m	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 30, 1896	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Mathias Matthews			14. MOTHER'S MAIDEN NAME Hattie Cross		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT George Matthews 4202 W. Rogers Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Carcinoma Lung			CAUSE OF DEATH (A) DUE TO from history. Hospital in City Hospital. (B) DUE TO Medical Examiner was called & released body. (C) DUE TO Not Known.		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-3 minutes 6-18 1967 to 19 , that (I) (we) last saw the deceased alive on 6-18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE J. J. Sullivan			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-18-67
23C. PHYSICIAN'S NAME (Type) BonSecours Hospital			23D. ADDRESS BonSecours Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/22/67		24C. NAME OF CEMETERY or CREMATORY Western Star Cem.	
24D. LOCATION (City, town, or county) (State) Cotonsville Md		24E. NAME OF REGISTRAR W. J. Sullivan		24F. FUNERAL DIRECTOR Williams Funeral Home 3977 Broadway St	
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		25B. NAME OF REGISTRAR W. J. Sullivan		25C. FUNERAL DIRECTOR Williams Funeral Home 3977 Broadway St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5950					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 67 5950				
1. NAME OF DECEASED (Type or Print) <u>Snowden, Isaac</u>					2. DATE AND HOUR OF DEATH <u>6/19/67</u> <u>11:50 P</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>					A. STATE <u>Maryland</u> B. COUNTY <u>Carroll Co.</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>56-00</u>				
					D. STREET ADDRESS (If rural, give location) <u>Springfield State Hosp.</u>				
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 13, 1885</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track Walker</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>R.R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Prince Geo. Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Samuel Snowden</u>					14. MOTHER'S MAIDEN NAME <u>Elvora Chittam</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>U.S.</u>		17. INFORMANT <u>Chart</u>		
18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CVA</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Severe, acute, menia</u>					<u>5 hr.</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Bleeding from stomach</u>					<u>8 hr.</u>				
19A. DATE OF OPERATION <u>—</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>6/19 1967</u> to <u>6/19 1967</u> that (I) (we) last saw the deceased alive on <u>6/19 1967</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Peter Shrac Nymay</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/19/67</u>		
23C. PHYSICIAN'S NAME (Type) <u>Peter S. Nymay</u> M.D.					23D. ADDRESS <u>University Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/23/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Catholic Cem Balto Md.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
25A. DATE RECEIVED BY HEALTH DEPT. <u>JUN 20 1967</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>			25C. FUNERAL DIRECTOR <u>Williams Funeral Home 300 N. Howard St.</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH	
67 5951		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
		LIMOS M. LAWRENCE	
2. DATE		6-17-67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL) BALTIMORE D. STREET ADDRESS (If rural, give location) 1131 E. NORTH AVE.	
THE JOHNS HOPKINS HOSPITAL			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH
MALE	NEGROID		x1-26-15
9. AGE (In years lost birthday)		10. CITIZEN OF WHAT COUNTRY?	
52		U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
Chaffell		Transfer Co.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
LIMOS		ESTELL HOLLAND	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		218-01-4088	
17. INFORMANT		ADDRESS	
Alexander Lawrence		1038 N. Supreme Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO	
Pneumococcal pneumonia		Staph	
ANTECEDENT CAUSES		(B) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO	
II		Thrombocytopenia & leukopenia	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2			
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
Yes		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from 6/17/67 19 to 6/17/67 19, that (I) (we) last saw the deceased alive on 6/17/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		21F. HOW DID INJURY OCCUR?	
23A. SIGNATURE		23B. DATE SIGNED	
John S. Sargent, M.D.			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
JOHN S. SERGENT, M.D.		THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		6-21-67	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
National Cemetery		Baltimore, Md.	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
JUN 20 1967		Rudolph J. Collick	
25C. FUNERAL DIRECTOR		ADDRESS	
2431 E. Oliver St			

DEPARTMENT
OF HEALTH

Registered No. 67
HOUR OF DEATH 5:00 P

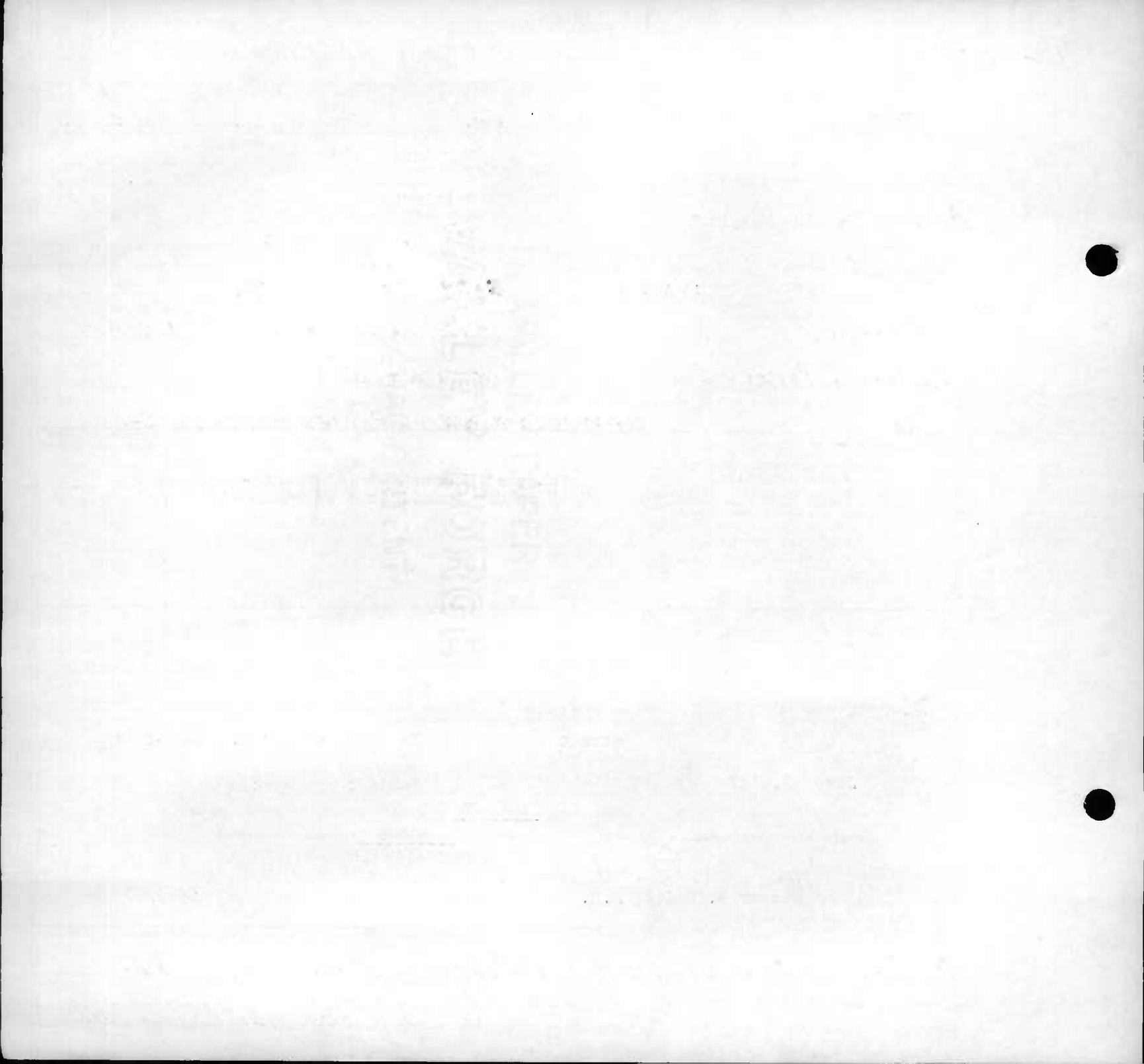
8:00 P
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ed if institution; residence before admission)

4-09

BIRTH No. 67 5952 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5952

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) RICHARD PORTER Jr.				2. DATE AND HOUR PRONOUNCED DEAD June 16, 1967 4:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-04			
5. SEX Male				6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY ?		8. DATE OF BIRTH 8-29-24		9. AGE (In years last birthday) 42	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Richard Porter Sr.				14. MOTHER'S MAIDEN NAME Nora Wood			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-20-8532		17. INFORMANT Mrs. Nora Porter 1001 Ensor St.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subdural Hemorrhage and Cranio-Cerebral injury complicated by Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DOXIN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) In front of 834 N. Bond Street 7-05			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) June 5, '67 9:30 P.M.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Subject was beaten up			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/16/67							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6-20-67		23C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery Baltimore, Md.		23D. LOCATION (City, town, or county) (State)	
24A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		24B. NAME OF REGISTRAR Robert E. Schubert		24C. FUNERAL DIRECTOR Rudolph J. Collick 243 E. Oliver St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5953 CERTIFICATE OF DEATH					Registered No. 67 5953				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) MISS. ALICE J. DuBREUIL					2. DATE AND HOUR OF DEATH JUNE 15, 1967				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION LONG GREEN NURSING HOME					A. STATE MD.				
(If not in hospital or institution, give street address or location)					B. COUNTY 13-07				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 3915 BEECH AVE.				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH NOV. 14, 1877	9. AGE (In years last birthday) 89 YRS.	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TEACHER			10B. KIND OF BUSINESS OR INDUSTRY WASHINGTON, D.C.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME GEORGE A. DuBREUIL					14. MOTHER'S MAIDEN NAME ALICE WALSH				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT COL. THEBAUD				ADDRESS
					114 W. UNIVERSITY PKWY				
18. 420-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Hypertensive Arteriosclerotic Coronary V. Disease and Sclerosis Acute heart failure					CAUSE OF DEATH years.				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from 23 Aug. 1960 to 15 June 1967 , that (I) (we) last saw the deceased alive on June 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Joseph E. Mears Jr.					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 16 June '67	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS 2725 N. Charles St. Balto. 18				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE JUNE 19 1967		24C. NAME OF CEMETERY or CREMATORY Loudon Park			24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967			25B. NAME OF REGISTRAR H. W. MEARS & SON			25C. FUNERAL DIRECTOR ADDRESS 805 N. CALVERT ST.			

June 10, 1967

Dear Mr. [illegible]

Enclosed for you are

two copies of the [illegible]

report on the [illegible]

of the [illegible]

of the [illegible]

Very truly yours,

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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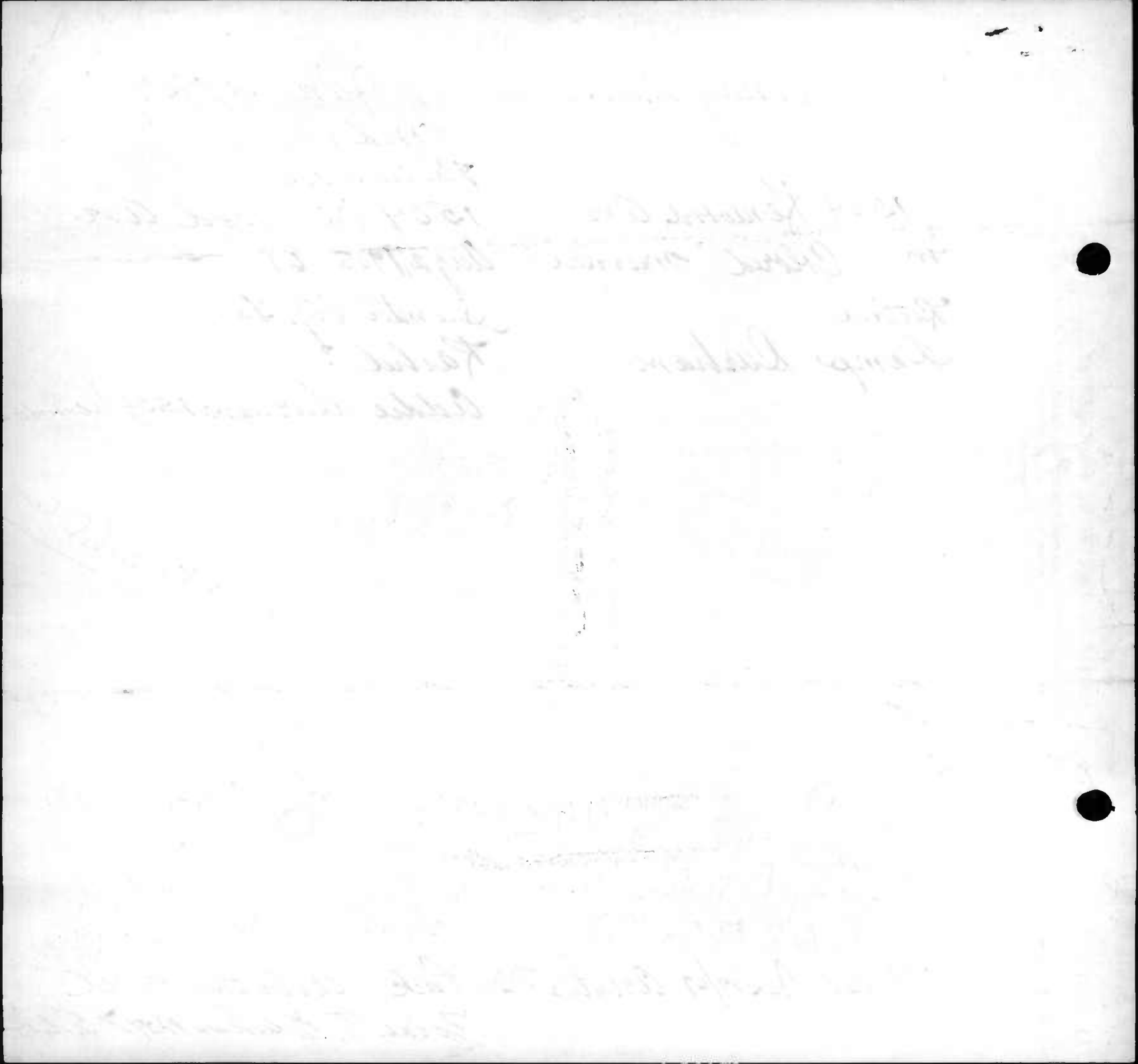
[illegible]

[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 5954		CERTIFICATE OF DEATH		67 5954	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Andy Durham		June 16, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
		A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
09504 Kenwood Ave		Baltimore			
D. STREET ADDRESS (If rural, give location)		1504 Kenwood Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M	Colored	Married	Aug 2, 1905	61	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Sumter City, Ga.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Hamp Durham		Rachel			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Addie Durham 1504 Kenwood Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Metastatic Carcinoma of Prostate		2 yrs. 0 mos. 0 days	
ANTECEDENT CAUSES		Prostate Carcinoma		Approved by Medical Examiner	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0 -				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10/1/65 to 1/27/67, that (H) (we) lost saw the deceased alive on 1/27/67 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Stanley D. Madison M.D.				6/19/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Stanley D. Madison, M.D.				2474 E Biddle, Bal., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		June 19/67		Arbutus Memorial Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 20 1967		Robert E. Jackson		Zorah T. E. Jackson 12297 Calver	



B-650
 Prepared by Medical Examiner
 FUNERAL DIRECTOR: IMPORTANT
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5955	
CERTIFICATE OF DEATH					
BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CHARLES BROWN		6-14-67 3:45 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
44 UNION MEMORIAL HOSP			MD		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BARTINONE		
			D. STREET ADDRESS (If rural, give location)		
			7 E NORTH AVE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
M	W	-	JUNE 15, 1905	61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED		P.		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
WM E. BROWN			ZORA WALLICK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES 2ND W. W.		198-104360		ARTHUR BROWN-1433 UNION AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO		
			Peritonitis secondary to perforation of pyloric ulcer.		
			(B) DUE TO		
			(C) DUE TO		
			Interval BETWEEN ONSET AND DEATH		
			In home		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6-13-67 19 to 6-14-67 19, that (I) (we) last saw the deceased alive on 6-14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Edilberto G. Gozo Jr.				6-14-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
EDILBERTO G. GOZO JR.				THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/19/67		Balto National	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 20 1967		Robert E. Taylor		Austin E. Donovan-3818 Roland Ave	

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

BEULAH

JENKINS

2. DATE AND HOUR PRONOUNCED DEAD

June 19, 1967

3:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

757 Carroll Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

3-30-92

9. AGE (In years
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BOTTLER

10B. KIND OF BUSINESS OR INDUSTRY

DISTILLERY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY

USA

13. FATHER'S NAME

Oscar E. Rodman

14. MOTHER'S MAIDEN NAME

Margaret Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216102920

17. INFORMANT

Melba Metger

ADDRESS

271 W. Bane St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

6/19/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/22/67

23C. NAME OF CEMETERY or CREMATORY

Mt Olivet Cem

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

JUN 20 1967

24B. NAME OF REGISTRAR

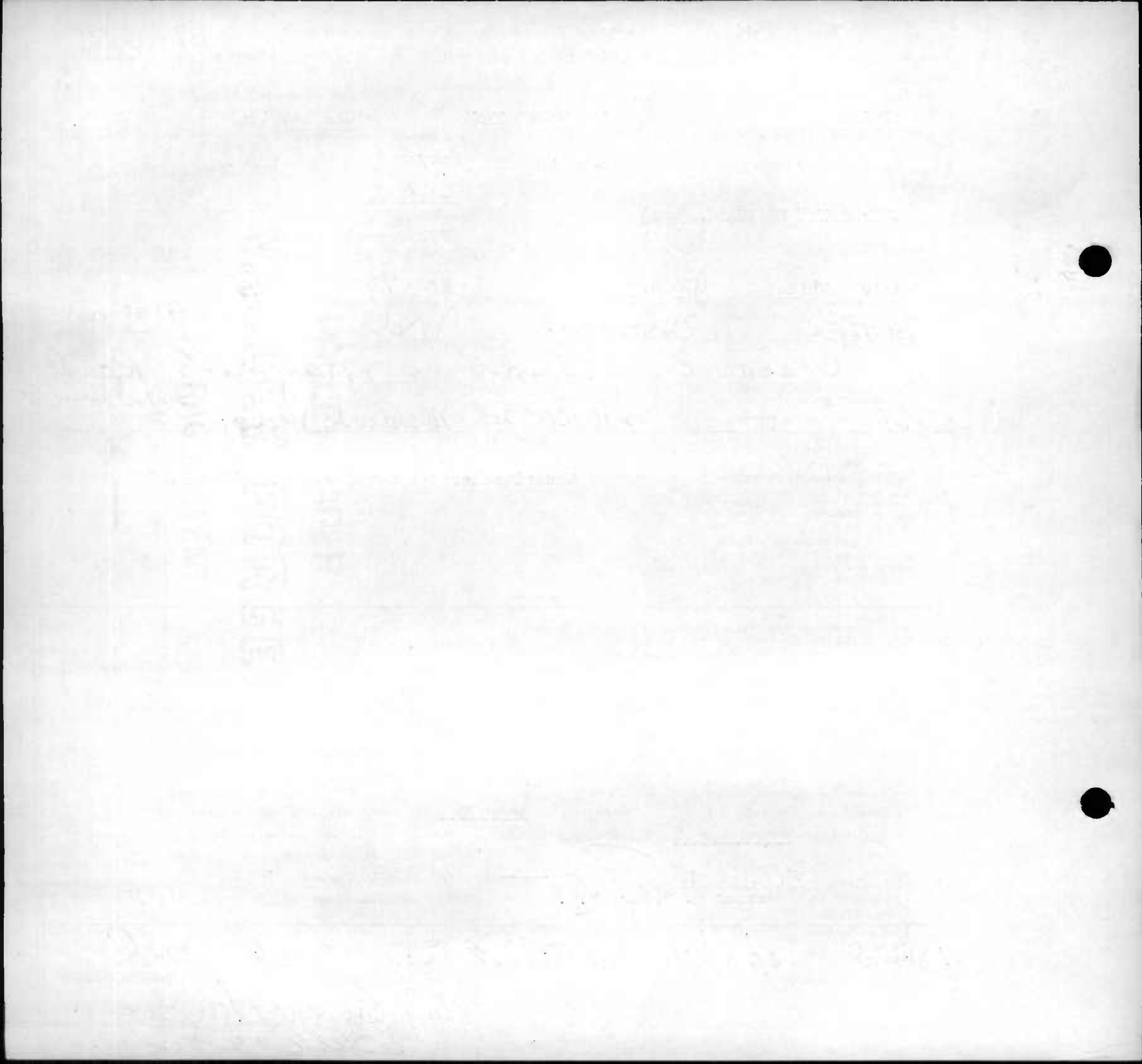
Robert E. Jackson

24C. FUNERAL DIRECTOR

John J. Cowan & Son Inc

ADDRESS

Baltimore Md



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MARY DOROTHY

Mary Dorothy Hamilton

HAMILTON

2. DATE AND HOUR OF DEATH

17 JUNE, 1967 4 45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Dundalk

D. STREET ADDRESS (If rural, give location)

816 Oakleigh Beach Road

21222

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5-6-1914

9. AGE (In years
last birthday)

53

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Lab. Tech.

10B. KIND OF BUSINESS OR INDUSTRY

Crosse & Blackwell

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Charles Wildberger

14. MOTHER'S MAIDEN NAME

Mary Catherine Swisher

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

212-22-5269

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue

21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7 JUNE, 1967 to 17 JUNE, 1967,
that (I) (we) last saw the deceased alive on 17 JUNE, 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Daniel D. Foote

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

17 JUNE, 1967

23C. PHYSICIAN'S
NAME (Type)

Daniel D. Foote

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/20/67

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

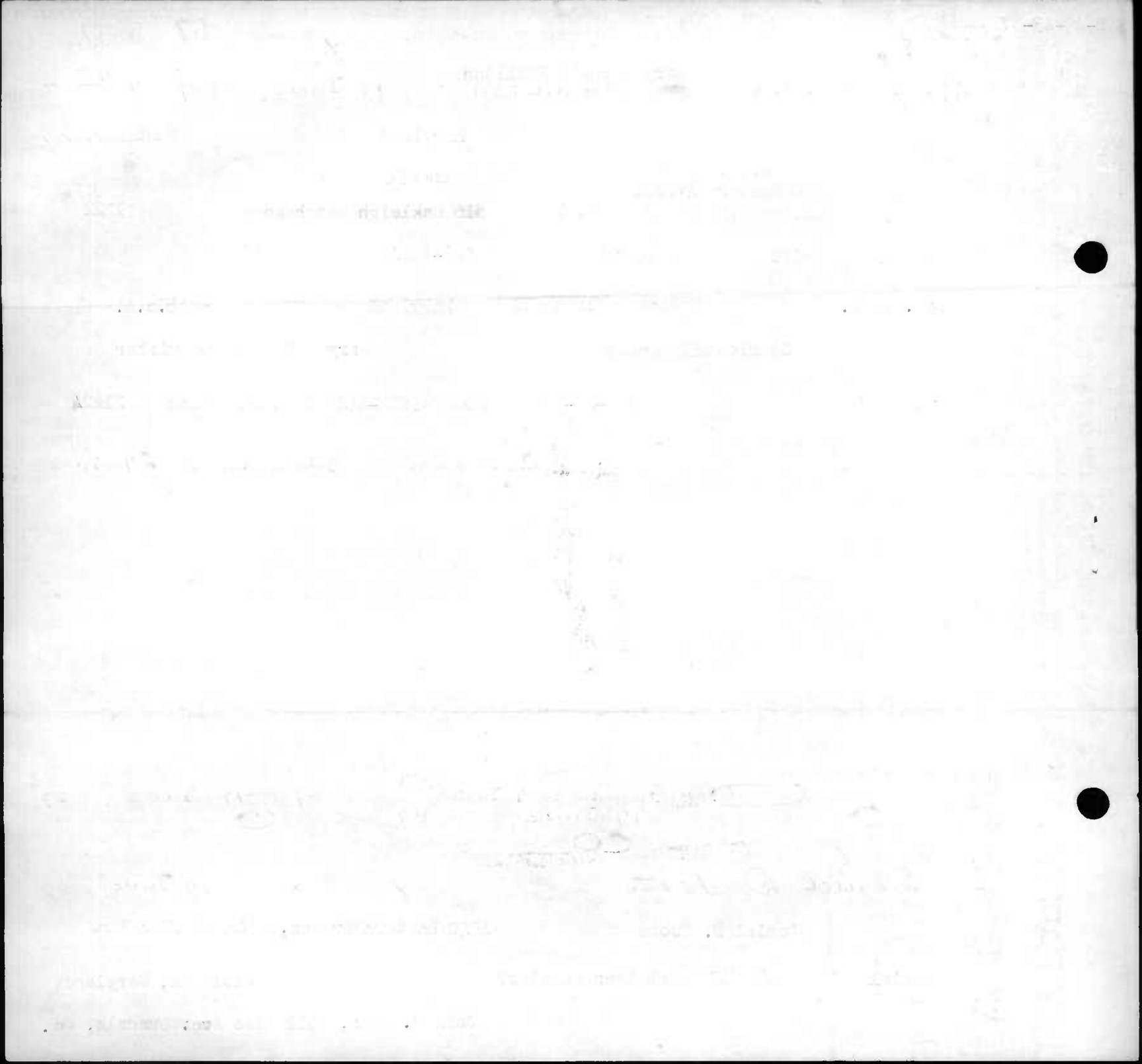
25C. FUNERAL DIRECTOR

ADDRESS

John J. Duda, 7922 Wise Ave. Dundalk, Md.

FUNERAL DIRECTOR: IMPORTANT

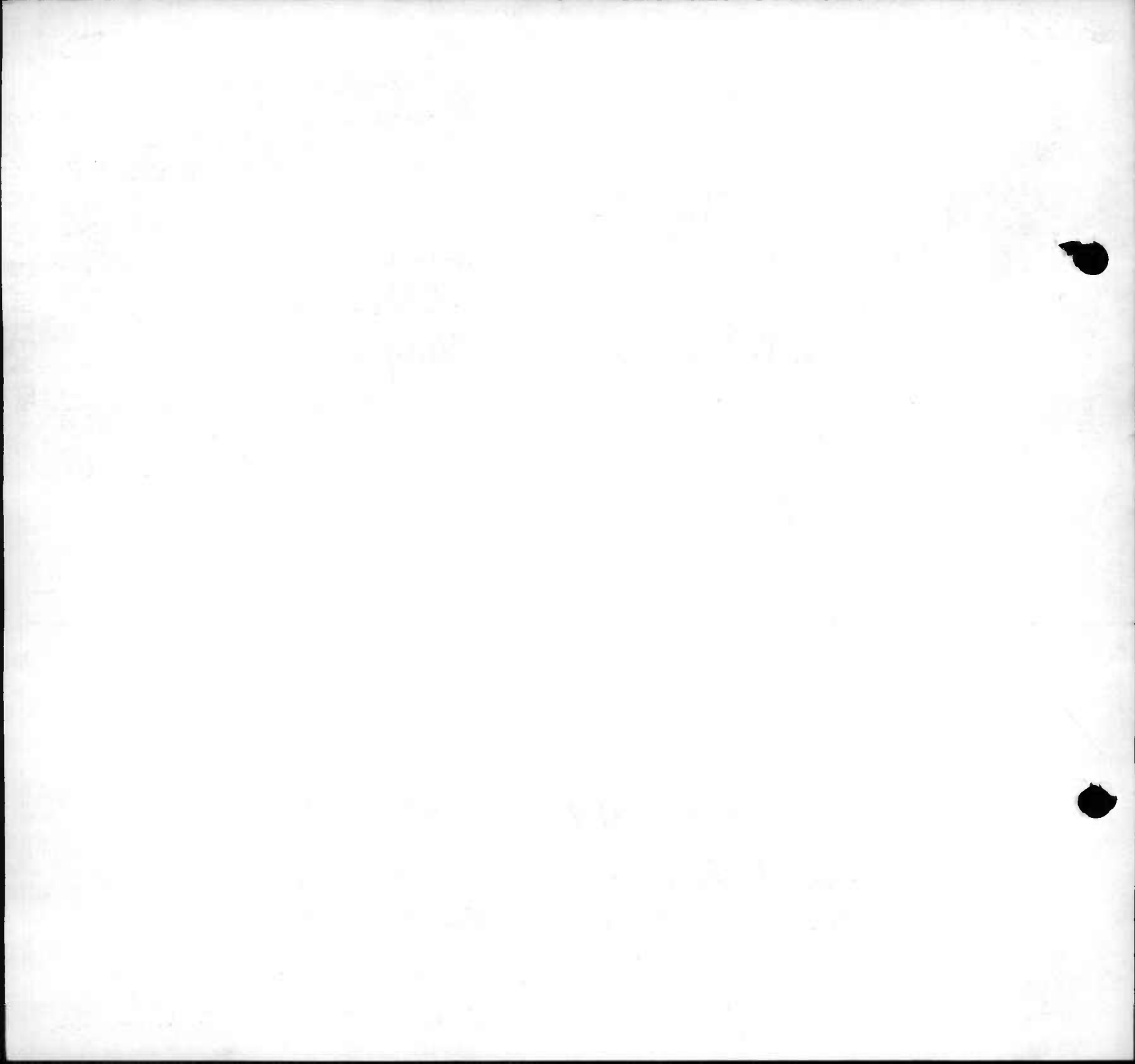
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 67-12144 67 5958						CERTIFICATE OF DEATH			Registered No. 67 5958 7		
1. NAME OF DECEASED (Type or Print) Goetz, Baby Boy						2. DATE AND HOUR OF DEATH 6-17-67 10:55 AM					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Newborn Infant C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) BALTO. MD. 21229					
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NM		8. DATE OF BIRTH 6-15-67		9. AGE (In years last birthday) 37 1/2		10. CITIZEN OF WHAT COUNTRY? U.S.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10B. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) BALTO. MD.						12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME George H. Goetz						14. MOTHER'S MAIDEN NAME Mary Burkett					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO						16. SOCIAL SECURITY NO. —					
17. INFORMANT George Goetz						ADDRESS 4425 Cedar Garden Rd.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II						CAUSE OF DEATH (A) DUE TO Hyaline Membrane Disease (B) DUE TO — (C) DUE TO —					
19A. DATE OF OPERATION 6/15						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO					
20A. AUTOPSY? (Yes or No) NO						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/15 19 67 to 6/17 19 67 , that (I) (we) last saw the deceased alive on 6/17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Grace P. Ayunyar						23B. DATE SIGNED 6/17/67					
23C. PHYSICIAN'S NAME (Type) GRACE P. AYUNYAU						23D. ADDRESS Bon Secours Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 6-20-67		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL				24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967				25B. NAME OF REGISTRAR Robert E. Sullivan				25C. FUNERAL DIRECTOR Francis H. Miller			
								ADDRESS 2101 Frederick Ave			



FUNERAL DIRECTOR: IMPORTANT

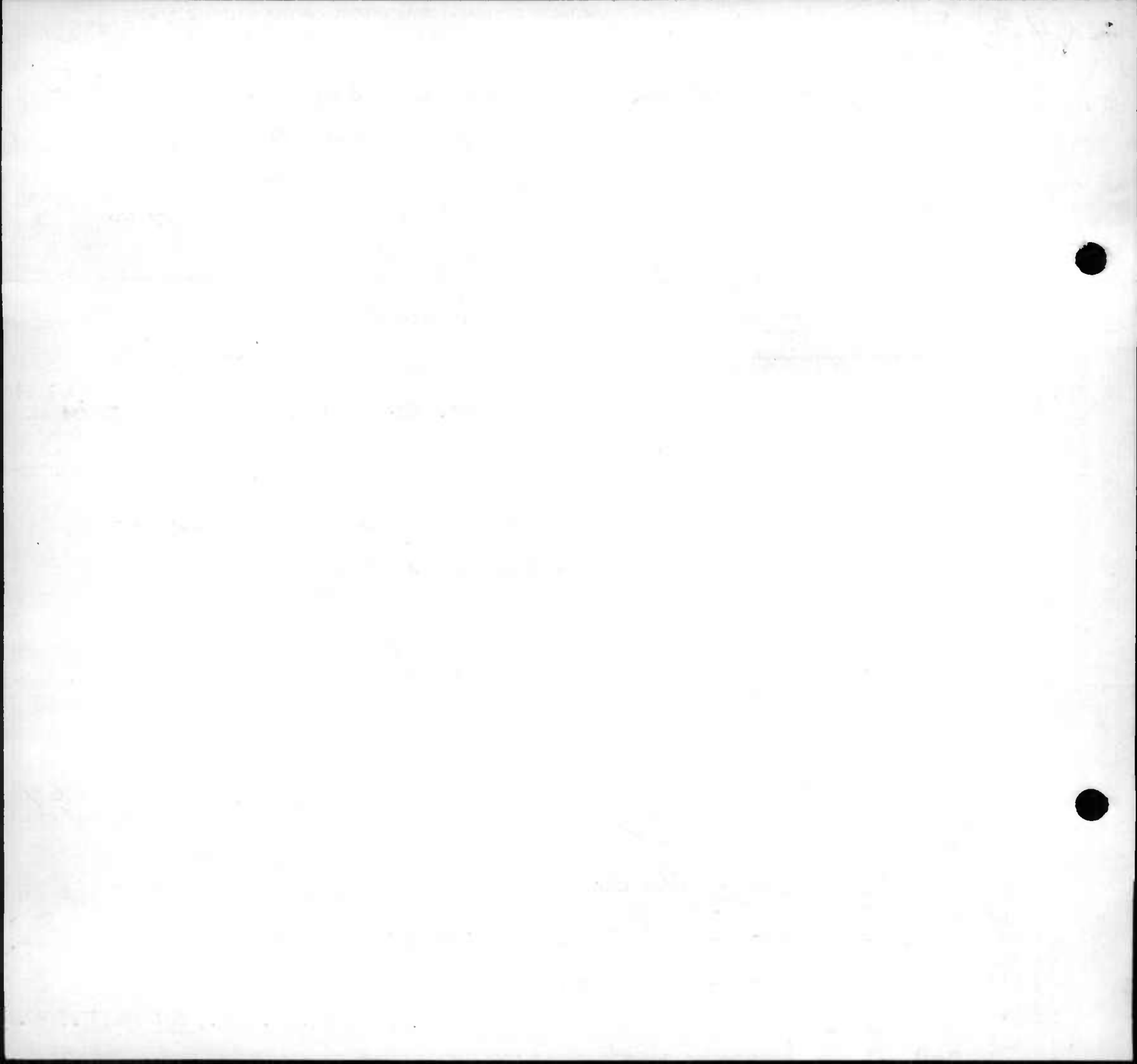
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5959 CERTIFICATE OF DEATH					Registered No. 67 5959				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) HALL, MRS. MARY ELLEN					2. DATE AND HOUR OF DEATH June 19/67 12:00 noon				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 18-03				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 BON SECOURS HOSPITAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
D. STREET ADDRESS (If rural, give location) 645. CARROLLTON AVE.									
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9/1/99	9. AGE (In years last birthday) 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Michael Connolly			14. MOTHER'S MAIDEN NAME Catherine McKewin			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. -			17. INFORMANT Mr. George D. Hall			ADDRESS Rockhill			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.11-260X (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes mellitus & C.H.F.					INTERVAL BETWEEN ONSET AND DEATH 9				
MEDICAL CERTIFICATION									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 14 19 67 to June 19 19 67 that (I) (we) last saw the deceased alive on June 19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE A.M. Ghiladi					23B. DATE SIGNED 8/19/67				
23C. PHYSICIAN'S NAME (Type) Abdolhamid Ghiladi					23D. ADDRESS Bon Secours Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/23/67		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		24D. LOCATION (City, town or county) (State) 4302 Old Frederick Rd.			
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		25B. NAME OF REGISTRAR R. C. E. E. E.		25C. FUNERAL DIRECTOR John J. Leary & Son Inc.		ADDRESS 75 Md.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

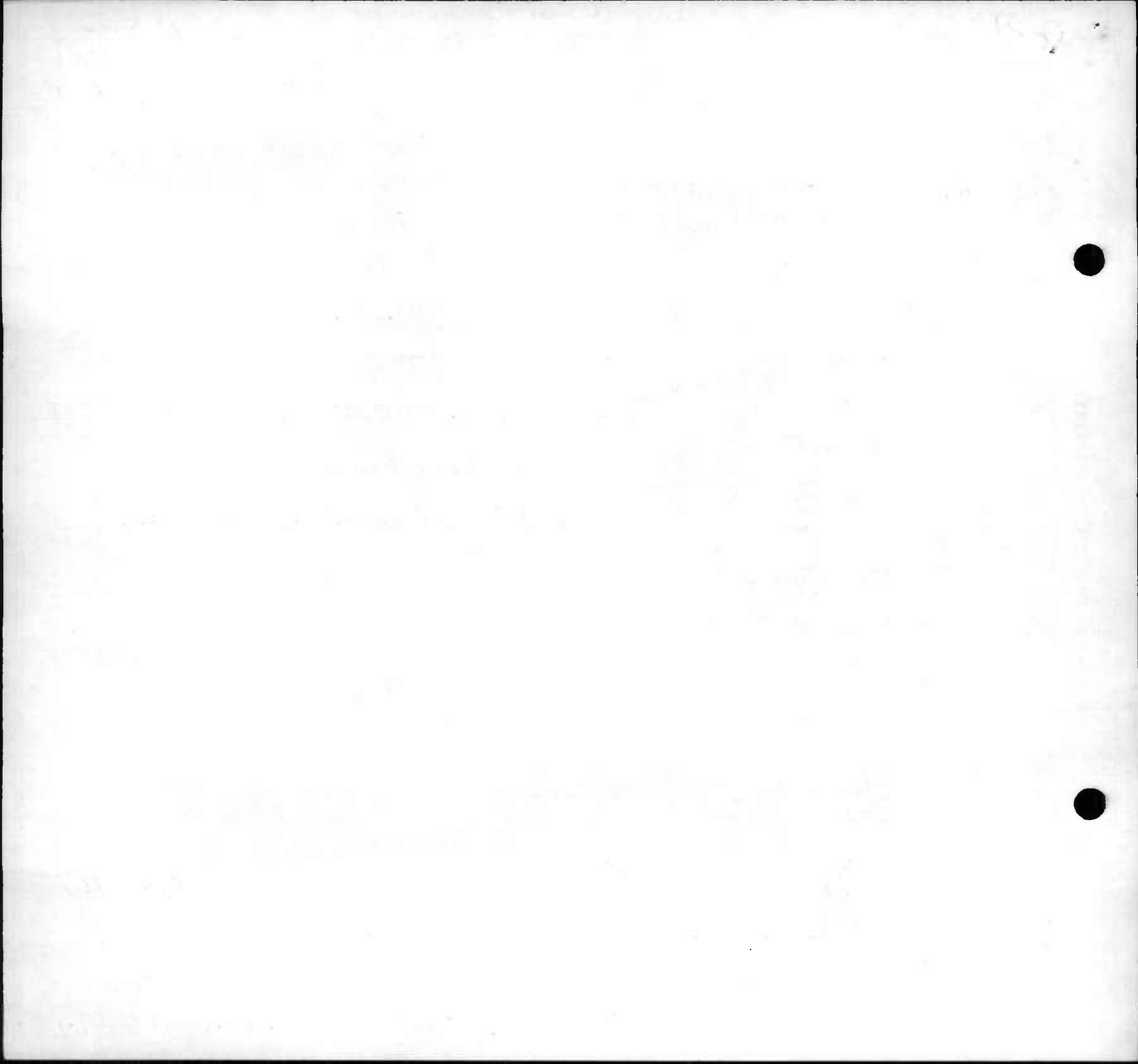
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5960</u>	
BIRTH NO. <u>67 5960</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Israel M. MILLER</u>				6/13/67 11 45 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u> <u>38</u>				A. STATE <u>MARYLAND</u> B. COUNTY <u>27-20</u>	
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
				D. STREET ADDRESS (If rural, give location) <u>7121 PARK HTS AVE #15</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>6/15/20</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>MEYER</u>		
14. MOTHER'S MAIDEN NAME <u>BESSIE</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			17. INFORMANT <u>MRS. HELEN MILLER, 7121 PARK HEIGHTS AVENUE APT 510</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Gastroenteritis</u>			19. INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Giant Follicular Cell Lymphoma</u> <u>Diabetes mellitus</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/12</u> 19 <u>67</u> to <u>6/13</u> 19 <u>67</u> . that (I) (we) last saw the deceased alive on <u>6/13</u> 19 <u>67</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sandra Z. Salan</u> M.D.				23B. DATE SIGNED <u>6/13/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>SANDRA Z. SALAN</u> M.D.				23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/16/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>BETH TELLER</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 20 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REIST., RD.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

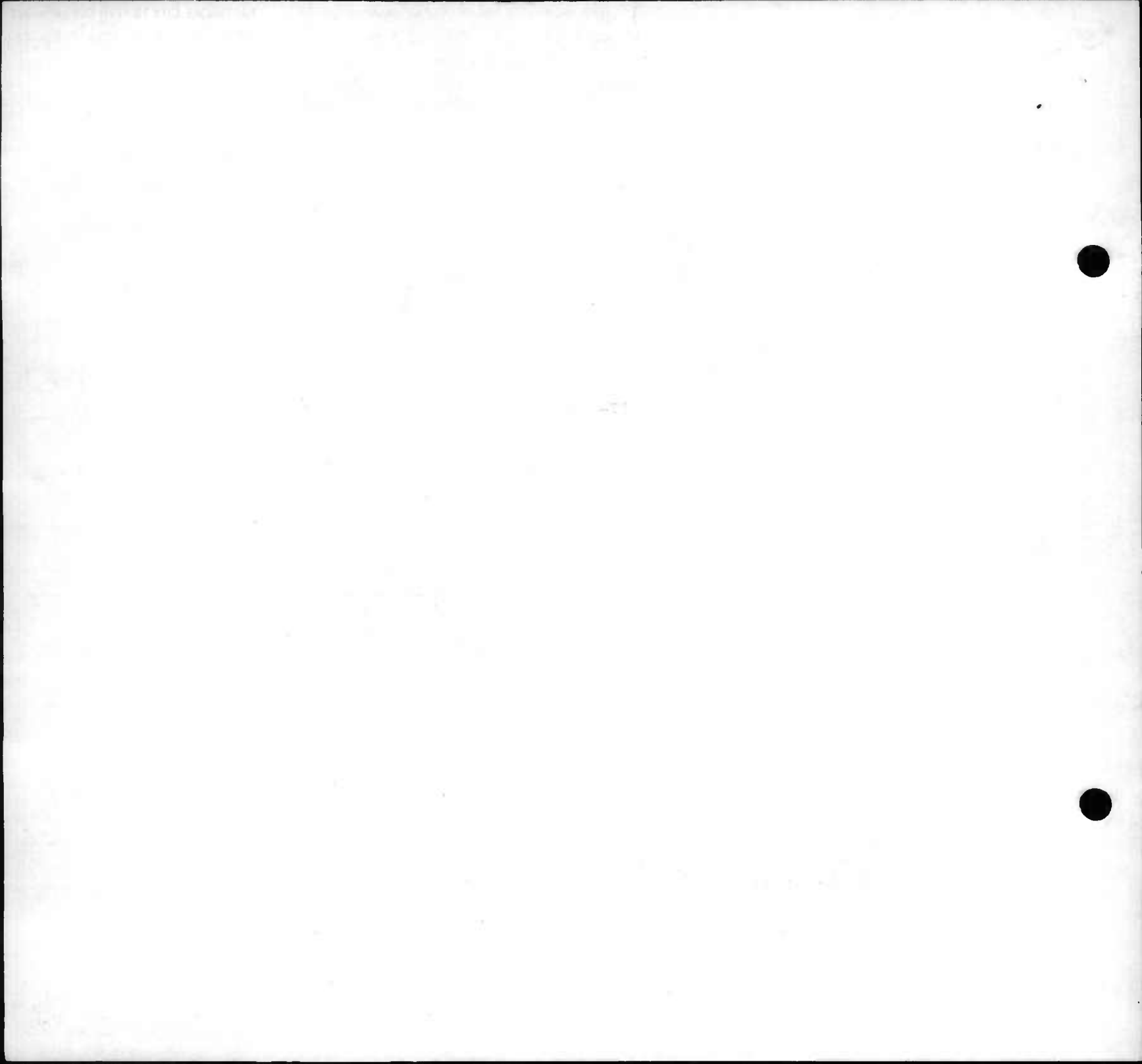
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 6152	
BIRTH NO. 67 5981		67 5981		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Beckes, Laura		2. DATE AND HOUR OF DEATH 6/15/67 1 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-20		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION MONTABELLO STATE HOSP. BALTIMORE, MD		D. STREET ADDRESS (If rural, give location) 3903 ROSECREST AVENUE			
5. SEX F	6. RACE W	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12-16-17	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) PHILA., PA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MORRIS FRIEDLAND		14. MOTHER'S MAIDEN NAME GERTRUDE ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMATION ADDRESS MR. PHILIP BECHKES, 3903 ROSECREST AVENUE	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebral hemorrhage DUE TO (B) Internal Carotid aneurysm DUE TO (C) lft.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Young Lea Lew M.D.				23B. DATE SIGNED 6/15/67	
23C. PHYSICIAN'S NAME (Type) YOUNG HEA LEW M.D.				23D. ADDRESS MONTABELLO STATE HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/16/67		24C. NAME of CEMETERY or CREMATORY MIKRO KODESH BETH ISRAEL	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REIST., RD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

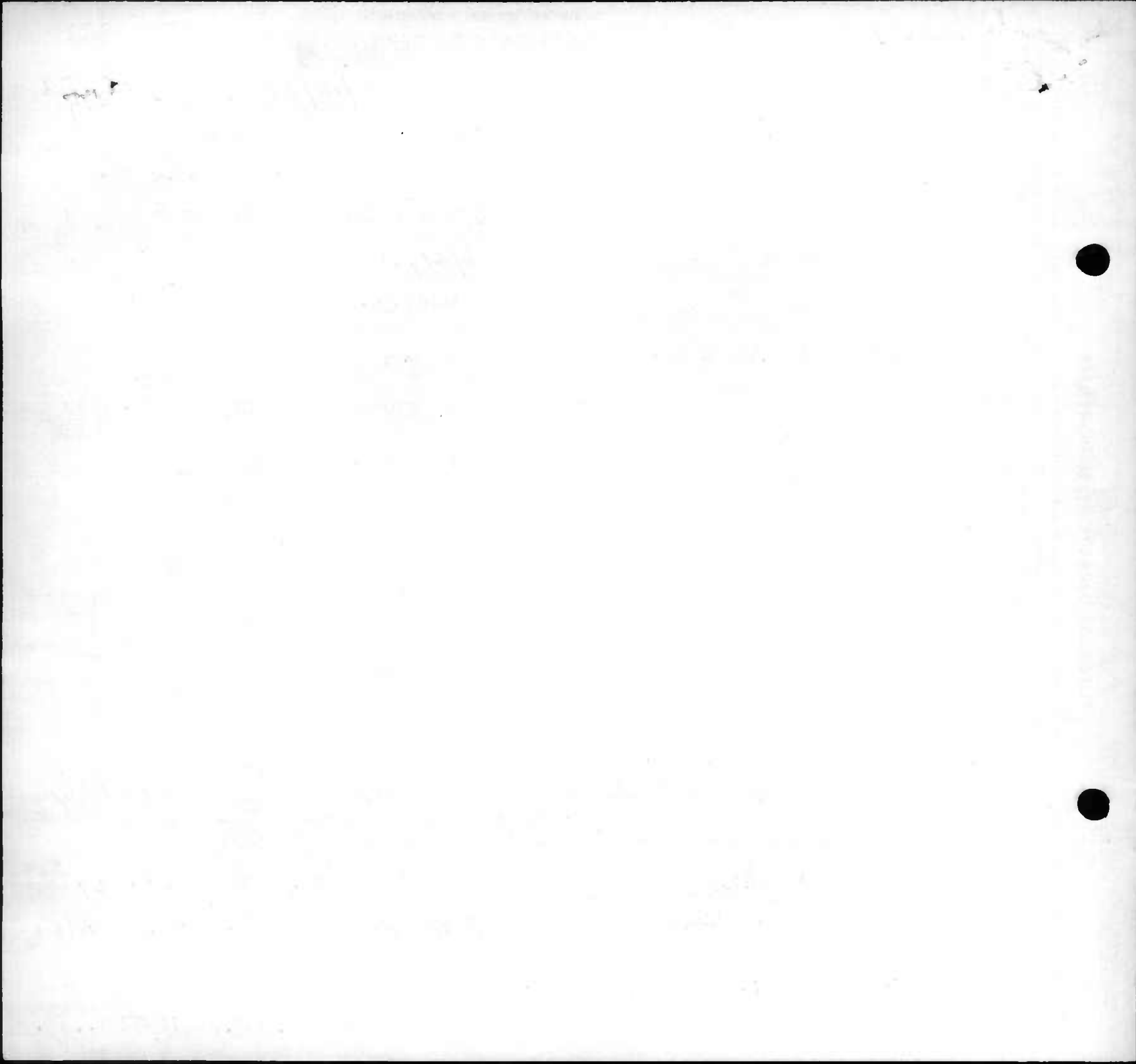
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5962	
BIRTH NO. 67 5962		M.E. CASE NO. VERA					
1. NAME OF DECEASED (Type or Print) Anna Baer				2. DATE AND HOUR OF DEATH June 13, 1967 8 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3923 Clarke Lane				A. STATE Maryland			
				B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-20			
				D. STREET ADDRESS (If rural, give location) 3923 Clarke Lane			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 11-13-1894	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Bakery Shop		11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Harris Baer				14. MOTHER'S MAIDEN NAME Rose Meier			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-32-9875A		17. INFORMANT Mrs Robert Paulson		ADDRESS 2706 Hanson Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) Acute Myocardial Insufficiency DUE TO (B) Coronary Art Disease DUE TO (C) _____		4 mos	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Renal Disease Diabetes Mellitus							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept 19 1966 to June 13 1967 , that (I) (we) lost saw the deceased alive on June 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leonard Kots				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 13/67	
23C. PHYSICIAN'S NAME (Type) LEONARD KOTS				23D. ADDRESS M.D. 11 SLADE AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 16/67		24C. NAME OF CEMETERY OR CREMATORY Beth Shalom Anshe Ezer		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967		25B. NAME OF REGISTRAR Ruth E. Taylor		25C. FUNERAL DIRECTOR Sol Leinson		ADDRESS Bess 2F - 6010 Reist Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

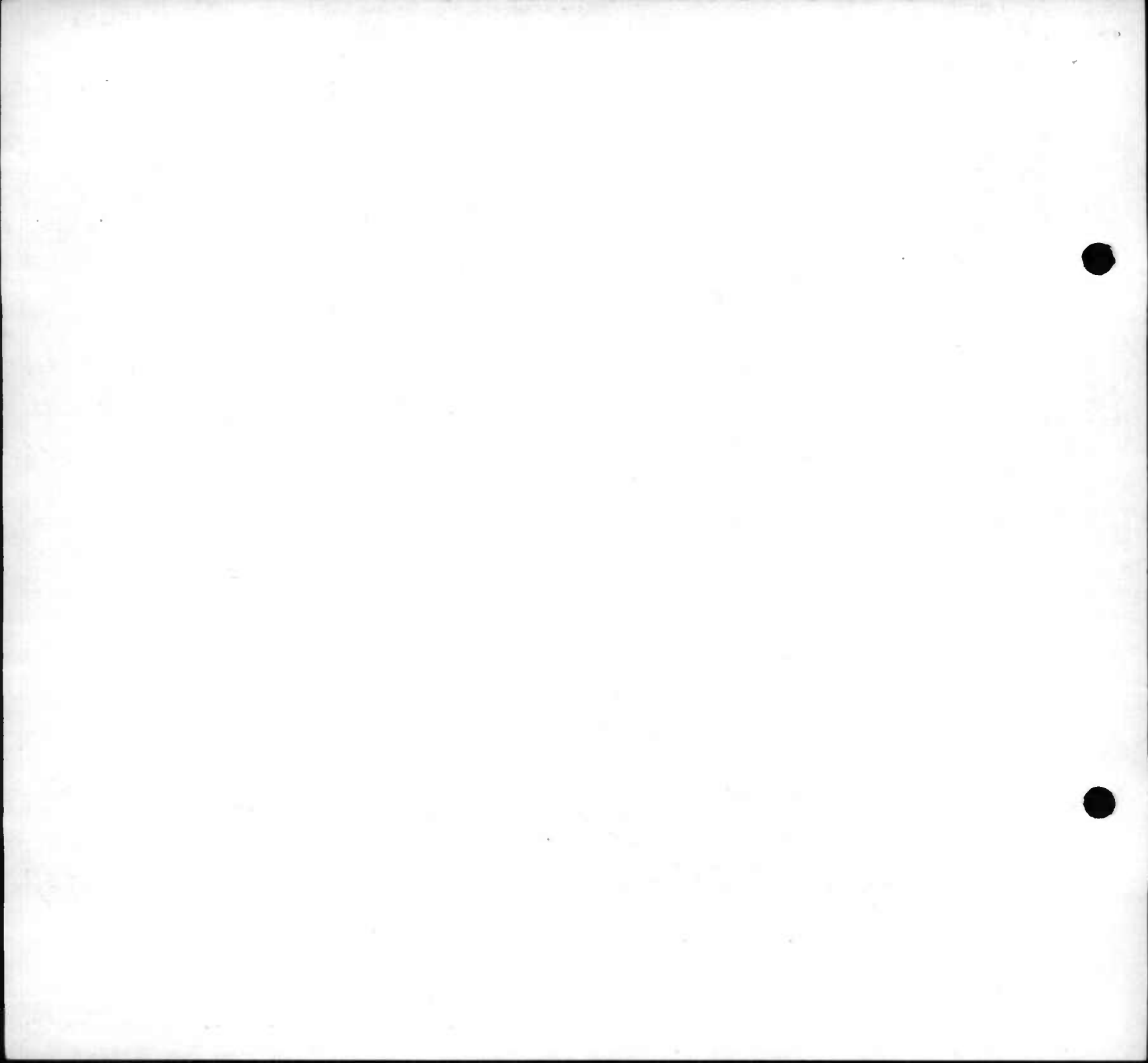
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5963	
BIRTH NO. 67 5963		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SCOTT YOUNG WORTH		2. DATE AND HOUR OF DEATH 6/16/67 1:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL #2		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-20			
		D. STREET ADDRESS (If rural, give location) 6002 BAYWOOD AVE., #9			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 6/29/56	9. AGE (In years last birthday) 10	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOLAR		10B. KIND OF BUSINESS OR INDUSTRY SCHOOL		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME BERNARD YOUNG WORTH		14. MOTHER'S MAIDEN NAME FRANCES KOGAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NO		17. INFORMANT MR. BERNARD YOUNG WORTH, 6002 BAYWOOD AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PRIMARY PULMONARY HYPERTENSION WITH RIGHT HEART FAILURE.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (H) (this hospital) attended the deceased from 6/17/67 to 6/16/1967 , that (H) (we) last saw the deceased alive on 6/16/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE K. Shaw		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/16/67	
23C. PHYSICIAN'S NAME (Type) K. SHAW		23D. ADDRESS M.D. SINAI HOSPITAL, BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/18/67		24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SOL LEVINSOHN & BROS. INC., 6010 REIST., RD.			



FUNERAL DIRECTOR: IMPORTANT

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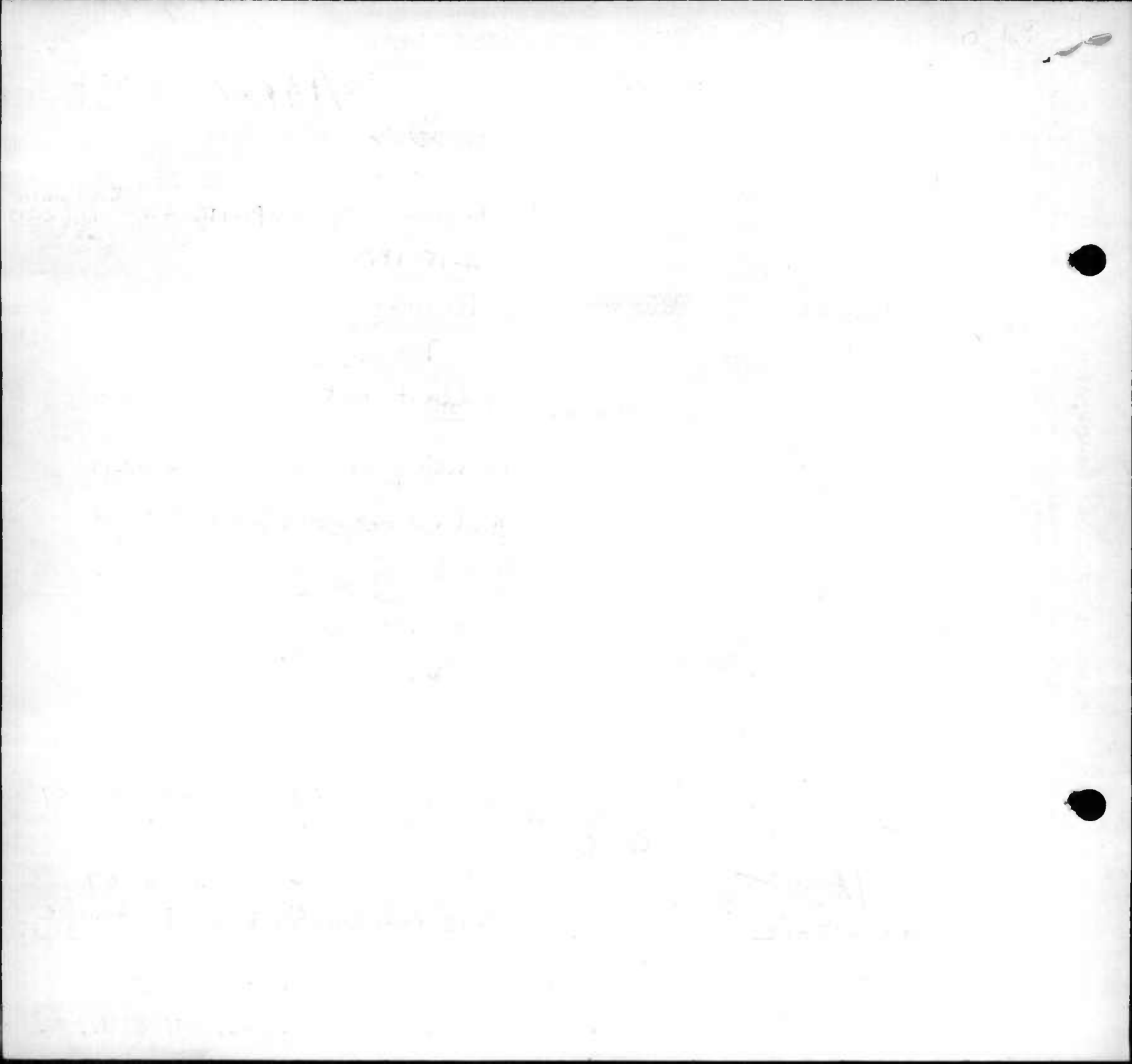
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5964	
BIRTH NO. 67 5964		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH JUNE 13, 1967 6:30 P.M.			
1. NAME OF DECEASED (Type or Print) STANLEY HARVEY BELFORD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Montgomery Co.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3312 BONNIE ROAD #8		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BETHESDA D. STREET ADDRESS (If rural, give location) 7501 DEMOCRACY BLVD., LAKESIDE TERR. APTS.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH NOV. 11, 1938	9. AGE (In years last birthday) 28	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY PHYSICIAN		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOSEPH BELFORD		14. MOTHER'S MAIDEN NAME ESTHER DICKMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-36-7073		17. INFORMANT MRS. PHYLLIS BELFORD, 3312 BONNIE ROAD #8	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Embryonal Ca of Testicles		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH ? - 6 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 30 19 67 to June 13 19 67 , that (I) (we) lost saw the deceased alive on June 13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph C. Matchar				23B. DATE SIGNED June 14, 1967	
23C. PHYSICIAN'S NAME (Type) DR. JOSEPH C. MATCHAR				23D. ADDRESS 6821 REISTERSTOWN ROAD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/16/67		24C. NAME OF CEMETERY OR CREMATORY NEW HAR SINAI	
24D. LOCATION GARRISON, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUN 20 1967			
25B. NAME OF REGISTRAR R. B. E. [Signature]		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

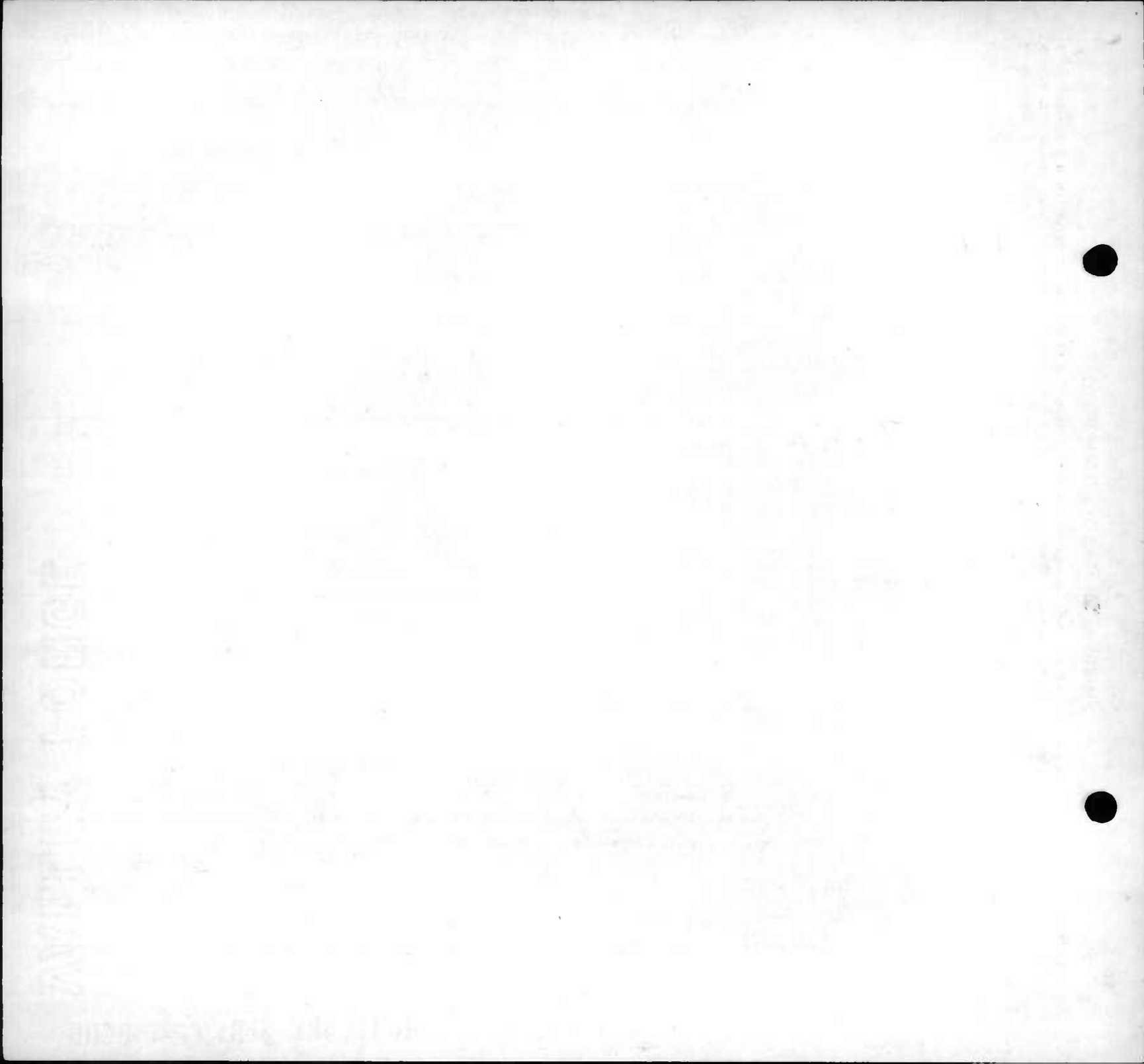
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 5965		67 5965	
CERTIFICATE OF DEATH					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		William KATZ			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE Md. B. COUNTY			
(If not in hospital or institution, give street address or location)		BALTIMORE			
9 LEVINDALE AGED HOME		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		Belvedere at Greenspring Ave. Baltimore Md. 21215			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	WHITE	MARRIED	4-15-1889	78	Bakery
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Bakery		RETAIL	Russia		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
? KATZ			? UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO			218-36-8009A		Albert Katz, 5314 LYNVIEW AVENUE
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES			2 days		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			12 yrs.		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6-12-1963 to 6-14-1967, that (I) (we) last saw the deceased alive on 6-14-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Adair				6-14-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Jose ARDAIZ				5912 Cross Country Blvd. Baltimore Md. 21215	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		6/16/67		SHAAREI ZION	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 20 1967		R. E. S. S. S.		SOL LEVINSON & BROS. INC., 6010 REIST., RD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

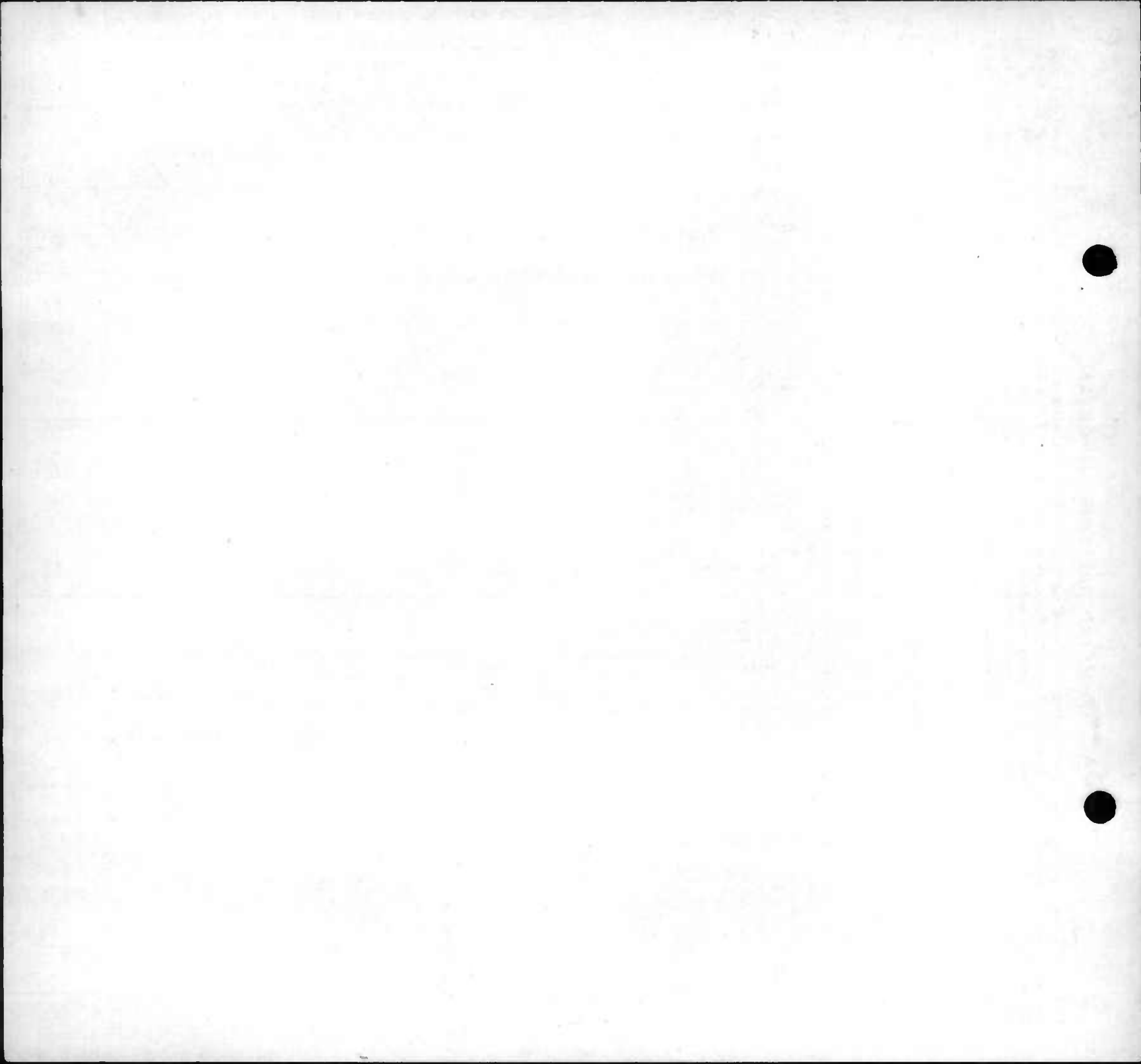
BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 67 5966
BIRTH NO. 67-11551 67 5966						CERTIFICATE OF DEATH
M.E. CASE NO.						
1. NAME OF DECEASED (Type or Print) McFADDEN BABY BOY			2. DATE AND HOUR OF DEATH 6/10/67 1 54 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 19-02			
			D. STREET ADDRESS (If rural, give location) 106 N. GILMORE ST.			
5. SEX M	6. RACE N	7. MARITAL STATUS NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 6/10/67	9. AGE (In years last birthday) 3 55	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		
13. FATHER'S NAME WILLIAM McFADDEN				14. MOTHER'S MAIDEN NAME DOROTHY KERNEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT CHART		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) prematurely DUE TO		INTERVAL BETWEEN ONSET AND DEATH birth	
			(B) _____ DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) _____			
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 0	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/10 19 67 to 6/10 19 67 , that (I) (we) last saw the deceased alive on 6/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
23A. SIGNATURE B. Luddy				23B. DATE SIGNED 6/10/67		
23C. PHYSICIAN'S NAME (Type) B. Luddy			23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE JUN 15 1967		24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND		
24D. LOCATION (City, town, or county)		24E. STATE (State)		24F. CITY, TOWN, OR COUNTY		
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1967		25B. NAME OF REGISTRAR John E. Fisher, M.D.		25C. FUNERAL HOME ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

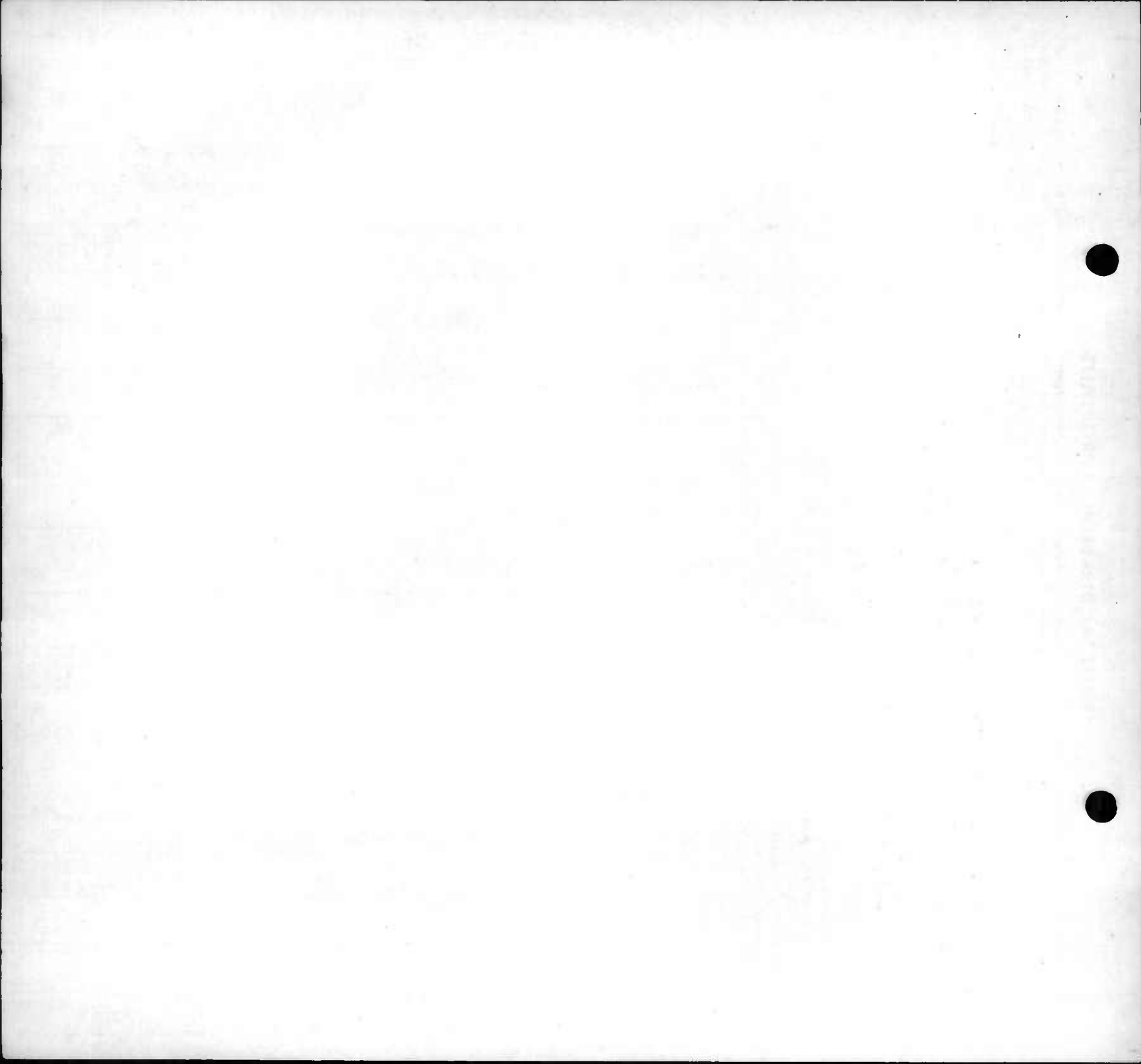
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5967	
BIRTH NO. 34-62-82		CERTIFICATE OF DEATH			
M.E. CASE NO. 67-09397 67 5967					
1. NAME OF DECEASED (Type or Print) Baby Boy Roberto		2. DATE AND HOUR OF DEATH 5.15.67 3.30 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 13-02			
		D. STREET ADDRESS (If rural, give location) 2211 Eutaw St.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 5.14.67	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Lee Roberto			14. MOTHER'S MAIDEN NAME Teremezia Greene		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 776 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Prematurity		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 16 hrs 8 mins.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 5.14.1967 to 5.15.1967 , that (H) (we) lost saw the deceased alive on 5.15.1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Misbah Khan				23B. DATE SIGNED 5.15.67	
23C. PHYSICIAN'S NAME (Type) MISBAH KHAN		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE JUN 18 1967		24C. NAME of CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5968</u>	
BIRTH NO. <u>67-07590 67 5968</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Baby girl Oden</u>		2. DATE AND HOUR OF DEATH <u>5/11/67</u> <u>3³⁰</u> <u>A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>-</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>25-33</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIV. of Md Hospital</u>		D. STREET ADDRESS (If rural, give location) <u>2625 Kent St #30</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, (NEVER MARRIED) WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>4/16/67</u>	9. AGE (In years last birthday) <u>24</u>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Larry Oden</u>			14. MOTHER'S MAIDEN NAME <u>Mary L. Taylor</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>D. Gary Benfield MD</u>		ADDRESS <u>MD</u>
18. <u>75451</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Congenital Heart Disease</u>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>24 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <u>Prematurity</u>		<u>"</u>	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/16/67</u> 19 to <u>5/11/67</u> 19, that (I) (we) last saw the deceased alive on <u>5/11/67</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>D. Gary Benfield</u> M.D.				23B. DATE SIGNED <u>5/11/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>D. GARY BENFIELD</u> M.D.				23D. ADDRESS <u>UNIV. OF MD, HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>JUN 15 1967</u>		24C. NAME OF CEMETERY, CREMATOR, AND LOCATION (City, town, or county) (State) <u>ANATOMY BOARD OF MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 21 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>UNIVERSITY MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BCHD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

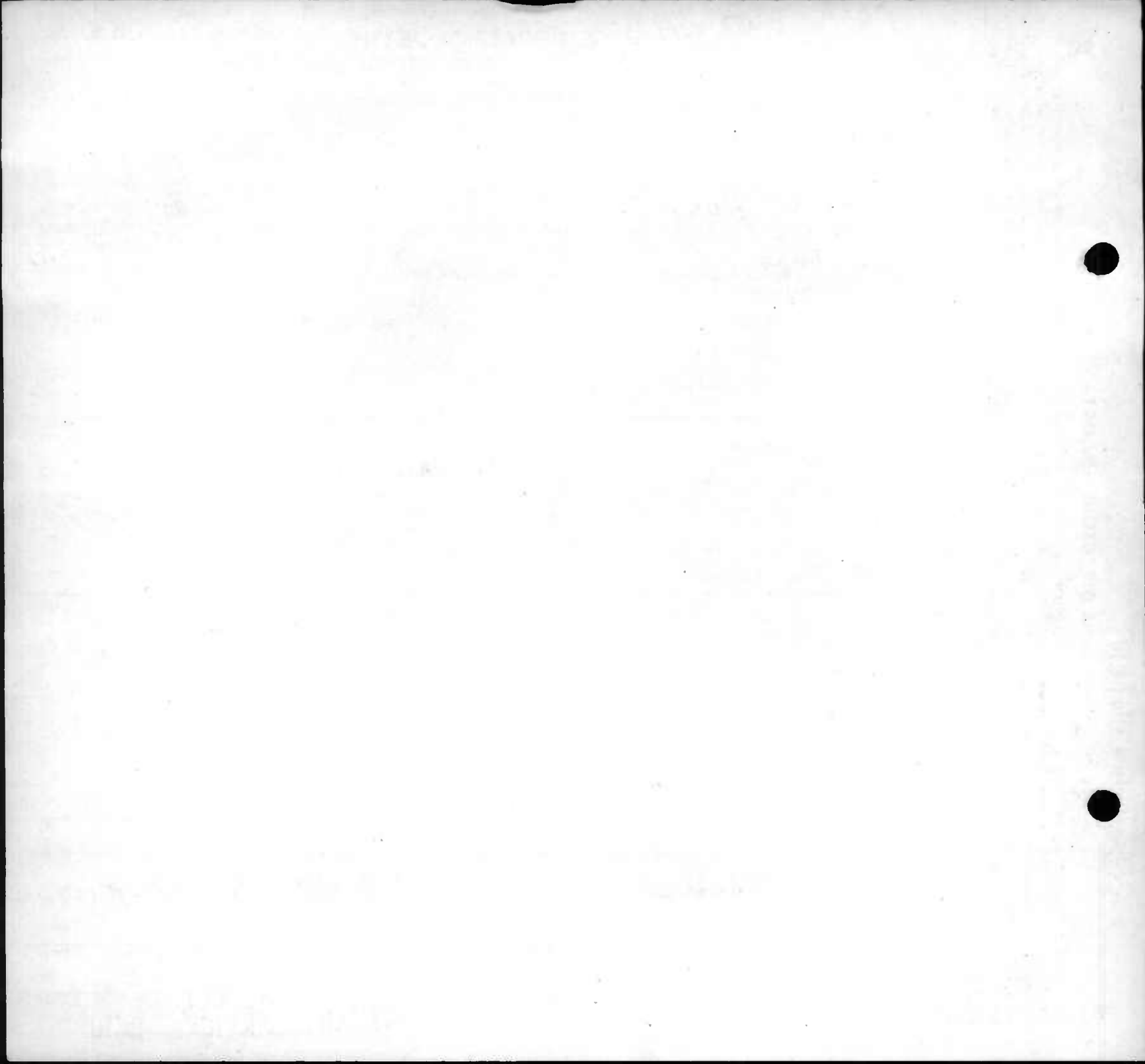
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67-09533 67 5969		CERTIFICATE OF DEATH		67 5969	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BABY GIRL LEMON		2. DATE AND HOUR OF DEATH 5-6-67 1 6 30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY OF MARYLAND HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1514 E. 28th			
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 5-6-67	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ???		14. MOTHER'S MAIDEN NAME BRENDA LEMON		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT CHART		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY FAILURE		CAUSE OF DEATH (A) RESPIRATORY FAILURE DUE TO (B) IMMATUREITY DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Life Life.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 5-6-67 19 to 5-6 19 67 , that (A) (we) last saw the deceased alive on 5-6 19 67 and that in (A) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M E Keeler		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-6-67	
23C. PHYSICIAN'S NAME (Type) MARY E. KEELER		23D. ADDRESS M.D. UNIV. OF MARYLAND HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE JUN 15 1967		24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1967		25B. NAME OF REGISTRAR R. E. E. E. E.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5970	
BIRTH NO. 67-11243		67 5970		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BABY GIRL HARPER		2. DATE AND HOUR OF DEATH 6/15/67 10:57 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL		A. STATE B. COUNTY Maryland			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-06			
		D. STREET ADDRESS (If rural, give location) 1605 Poplar Grove Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days Hours: Min. 34
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Alice Rosetta Harper			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PREMATURITY		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 34 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		ARTHROGRYPPOSIS CONGENITA MULTIPLEX			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 15 (10:24) 1967 to 6/15/67, that (I) (we) lost saw the deceased alive on 6/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. H. H. H.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/15/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE JUN 19 1967		24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1967		25B. NAME OF REGISTRAR J. E. H. H.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	



67 5971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 5971

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

CHARLES EDWARD SMITH

2. DATE AND HOUR OF DEATH

JUNE 19, 1967 8:20 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals
4940 Eastern Ave.
Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore
1025 Bennett Place 21223

D. STREET ADDRESS (If rural, give location)

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

8/19/11

9. AGE (In years
last birthday)

55

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland, A.A. Co.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Smith

14. MOTHER'S MAIDEN NAME

Sarah Smith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

BCH: Records 4940 Eastern Ave. Baltimore, Md. # 21224

18. 420.01

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C) DUE TO

Arteriosclerotic heart disease unknown

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary emboli.

Unknown

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from 6/2 1967 to 6/19 1967, that (I) ~~(we)~~ last saw the deceased alive on 6/19 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE

D. Tarsy

M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

6-18-1967

23C. PHYSICIAN'S NAME (Type)

D. Tarsy

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Ave. Baltimore, Maryland # 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 5972	
BIRTH NO. 67 5972											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) Hedwig Gittings						2. DATE AND HOUR OF DEATH 6/18/1967 10 PM.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Hood Conv. home.						A. STATE Md. B. COUNTY Baltimore					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
						D. STREET ADDRESS (If rural, give location) 631 N. Denison St.					
5. SEX F.		6. RACE W.		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH Oct/18/1884		9. AGE (In years last birthday) 82		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Cafeteria, Silver Spring						10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Engle						14. MOTHER'S MAIDEN NAME ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO. 215-03-2782		17. INFORMANT Gertrude Inscoe			
								ADDRESS 8110 Carroll Ln. 20910 Silver Spring / Md. 20910			
18. 7-20-07-15-6-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) Heart failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A.S.H.D. Genialine Atherosclerosis Probably En of Liver						CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
						(A) DUE TO		Days			
						(B) DUE TO		Years			
						(C)		Years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						Probably En of Liver		Months			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 5/21/1967 to 6/18/1967 , that (I) (we) last saw the deceased alive on 6/15/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Adnan M. Sonmez						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/18/1967			
23C. PHYSICIAN'S NAME (Type) ADNAN M. SONMEZ						23D. ADDRESS 1011 Frederick Rd. Balt. Md. 21228					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 21, 1967		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.		24D. LOCATION Balto. Md.		(City, town, or county)		(State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1967		25B. NAME OF REGISTRAR Robert E. Schwal		25C. FUNERAL DIRECTOR G. Truman Schwal		ADDRESS 3512 Frederick Ave.					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5973	
BIRTH NO. 67 5973				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) William Massel			2. DATE AND HOUR OF DEATH June 17, 1967 10:10 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Ardleigh Nursing Home 209 Rockrose Ave.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balt. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 53-00 1121 Elm Rd.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH May 30, 1884	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10B. KIND OF BUSINESS OR INDUSTRY Calvert Metal Co.	11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Massel			14. MOTHER'S MAIDEN NAME Mary L. Winkler		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. Elmer R. Massel 1121 Elm Rd. Balto. Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 422.1 I Chronic myocarditis with cardiac decompensation Arteriosclerotic cardio-vascular disease Pulmonary emphysema			CAUSE OF DEATH let. INTERVAL BETWEEN ONSET AND DEATH 1 yr. 2 yrs. 25 yrs.		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 18, 1967 to June 17, 1967 , that (I) (we) last saw the deceased alive on June 14, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd E. Saylor M.D.				23B. DATE SIGNED 6/19/1967	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor,				23D. ADDRESS M.D. 3902 Greenmount Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 20, 1967		24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 21 1967			
25B. NAME OF REGISTRAR G. Truman Schwab		25C. FUNERAL DIRECTOR ADDRESS 3512 Frederick Ave. Balto. Md.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5974		CITY HEALTH DEPARTMENT		Registered No. 67 5974	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) BORING, ELIZABETH			2. DATE AND HOUR OF DEATH JUNE 19th 1967 5:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital			A. STATE Maryland		
			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 12-02		
			D. STREET ADDRESS (If rural, give location) 3409 Greenway		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 12-09 '83	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? American					
13. FATHER'S NAME John H. Boring			14. MOTHER'S MAIDEN NAME Amelia Schier		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-48-2119		17. INFORMANT ADDRESS Mr. Herbert Schaefer 13 St. Michaels	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 600.1 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA - BILATERAL ACUTE CONFLUENT			INTERVAL BETWEEN WAY ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			(B) ACUTE PYELONEPHRITIS - BILATERAL		
			(C) PERINEPHRIC ABSCESS M. Lewman		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4 - 12 19 67 to 6 - 19 19 67 , that (I) (we) last saw the deceased alive on 6 - 19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fridtjofur Bjornsson M.D.				23B. DATE SIGNED 6-19 '67	
23C. PHYSICIAN'S NAME (Type) FRIDTJOFUR BJORNSSON M.D.				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-21-67		24C. NAME OF CEMETERY or CREMATORY Green Mount	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1967		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.	
				ADDRESS 6500 York Rd. Baltimore, Md. 21212	

John H. Barrow

Amelia Schier

Maryland

Amelia

FEMALE WHITE New married 15-01 '83

3409 Greenwood

Baltimore

Maryland

Union Memorial Hospital

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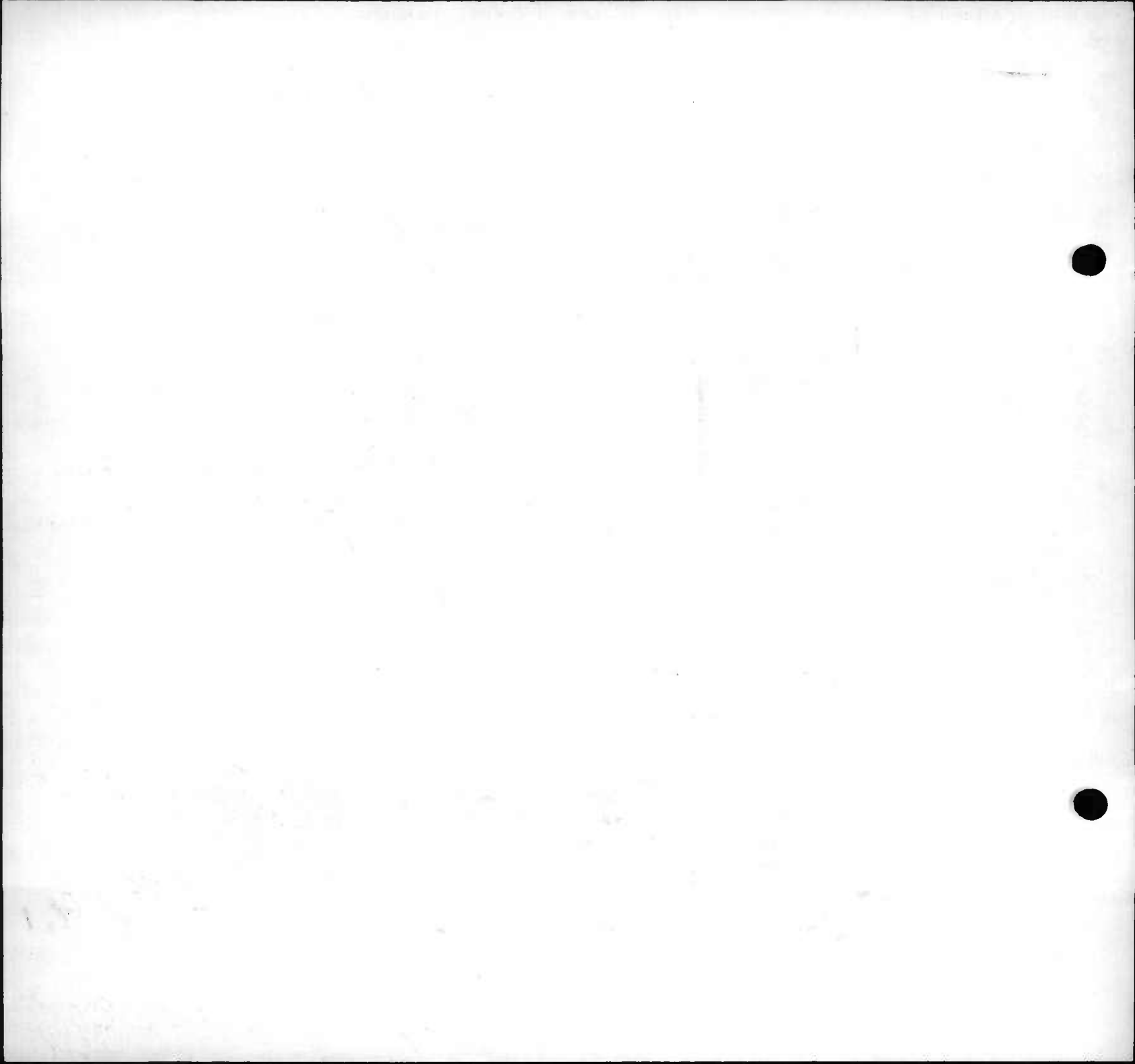
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5975					CERTIFICATE OF DEATH		Registered No. 67 5975		
1. NAME OF DECEASED (Type or Print) <i>Mildred C. Gardner</i>					2. DATE AND HOUR OF DEATH <i>6/18/67</i> <i>10 45 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE <i>MD.</i> B. COUNTY				
<i>091616 Parkman Ave</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> <i>23-52</i>				
					D. STREET ADDRESS (If rural, give location) <i>1616 Parkman Ave</i>				
5. SEX <i>Female</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>7/17/1919</i>	9. AGE (In years last birthday) <i>47</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bottler</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Calvert Distillery</i>			11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Anthony Vaccaro</i>			14. MOTHER'S MAIDEN NAME <i>Mary ?</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
			16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>Mr. Charles Gardner</i>		ADDRESS <i>above</i>		
18. <i>171X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH		
					(A) DUE TO <i>Mitostatic Carcinoma of Chest</i> <i>6 m</i>		(B) DUE TO <i>Carcinoma of the Cervix</i> <i>17 m</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>Jan 66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Pasture Rx</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1966</i> to <i>June 18 1967</i> , that (I) (we) last saw the deceased alive on <i>June 18 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>John H. Hebb</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6/20/67</i>		
23C. PHYSICIAN'S NAME (Type) <i>John H. Hebb</i>					23D. ADDRESS <i>812 Park Ave Balt</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/22/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Crest Lawn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Howard Co. Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 21 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <i>John J. Gowan + Son Inc.</i>		ADDRESS <i>Hollins 23rd St.</i>			



e-452

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) NORRIS		2. DATE AND HOUR PRONOUNCED DEAD June 16, 1967 10:38 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3603 Sollers Point Road	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 3-10-27
9. AGE (In years last birthday) 40		10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker		10B. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Eccles, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Collins		14. MOTHER'S MAIDEN NAME Bessie Growder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Beckley, W. Va.		18. Melton Mortuary Inc., 1200 Harper Rd.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Massive Internal Bleeding DUE TO laceration of Carotid Artery and Jugular Vein by Penetrating Iron Rod. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 6-16-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Construction site	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Whitehead Road and Security Blvd.		21D. HOW DID INJURY OCCUR? Subject fell 12 feet	
21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Subject fell 12 feet	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/16/67	
23A. BURIAL CREMATION, REMOVAL (Specify) Removal		23B. DATE 6-16-67	
23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State) Beckley, W. Va.	
24A. DATE REC'D BY HEALTH DEPT. JUN 21 1967		24B. NAME OF REGISTRAR Robert E. Spitz	
24C. FUNERAL DIRECTOR Wm. E. Johnson		ADDRESS 8521 Loch Raven Blvd. Balto 21204	

N 87412 67 5976

1550

67 5977

BALTIMORE CITY HEALTH DEPARTMENT

67 5977

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT F. INMAN, JR.

2. DATE AND HOUR PRONOUNCED DEAD

June 14, 1967

9:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 4 East 32nd Street, Apt. #403

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4 East 32nd Street, Apt. #403

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never married

8. DATE OF BIRTH

JUNE 24, 1967

9. AGE (In years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Switch Board Operator

10B. KIND OF BUSINESS OR INDUSTRY

Hostelry

11. BIRTHPLACE (State or foreign country)

Annapolis Md.

12. CITIZEN OF
WHAT COUNTRY?

US

13. FATHER'S NAME

Robert Frank Inman

14. MOTHER'S MAIDEN NAME

Marie Alice Lowman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

216-28-1621

17. INFORMANT

ADDRESS

Roberta Hardesty, Annapolis, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 15, 1967

23A. BURIAL CREMATION,
REMOVALS

23B. DATE

JUNE 20, 1967

23C. NAME OF CEMETERY OR CREMATORY

Ft. LINCOLN, Md.

23D. LOCATION

(City, town, or county)

(State)

Col MAR MANOR

MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

JUN 21 1967

24B. NAME OF REGISTRAR

Robert E. Springate

24C. FUNERAL DIRECTOR

HOPKINS Funeral Home
172 West St.

ADDRESS

ANNAPOLIS, Md

WALTER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67-12145 67 5978					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 67 5978				
1. NAME OF DECEASED (Type or Print) <i>Barry J. Virts</i>					2. DATE AND HOUR OF DEATH <i>6-15-67 8:30 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 BON SECOURS HOSP.</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>329 S. Payson St. Md</i>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 20-03</i>				
					D. STREET ADDRESS (If rural, give location) <i>329 S. Payson St</i>				
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>6-15-67</i>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>MD</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Jack Virts</i>				14. MOTHER'S MAIDEN NAME <i>Emma Ehrlich</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT <i>mother</i>			ADDRESS		
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) <i>Massive Aspiration</i> DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <i>prolonged illness</i> DUE TO				
					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Immaturity</i>									
19A. DATE OF OPERATION <i>6-15-67</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6-15-67</i> 19 <i>67</i> to 19 <i>67</i> , that (I) (we) lost saw the deceased alive on <i>6-15-67</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>A. A. Melocoton</i> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>6-15-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>A. A. MELOCOTON</i>					23D. ADDRESS <i>Bon Secours Hospital</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>6/16/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St. Peter's Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Belknap Md</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 21 1967</i>			25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i>			25C. FUNERAL DIRECTOR <i>Shirley Barry</i>			ADDRESS <i>Belknap Md</i>

Handwritten text, possibly a signature or date, located in the upper left corner of the page.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5978		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5978	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Edward Clarence Dodson		2. DATE AND HOUR OF DEATH 6/19/67 12 noon	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glen Burnie 52-00	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital		D. STREET ADDRESS (If rural, give location) 406-0 St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-23-06	9. AGE (In years last birthday) 61	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus driver		10B. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John W. Dodson		14. MOTHER'S MAIDEN NAME Marc Falls	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-9059		17. INFORMANT Patient chart	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction PULMONARY EDEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 6-8 hrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6-19-67 to 6-19-67, that (1) (we) last saw the deceased alive on 6-19-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John R. Vayhn Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-19-67	
23C. PHYSICIAN'S NAME (Type) John R. Vayhn Jr.		23D. ADDRESS Union Memorial Hospt., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-22-67		24C. NAME OF CEMETERY OR CREMATORY Kiser Cemetery	
24D. LOCATION (City, town, or county) (State) Kentucky, West Virginia		25A. DATE REC'D BY HEALTH DEPT. JUN 21 1967			
25B. NAME OF REGISTRAR R. E. Barber		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. 4905 York Road			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

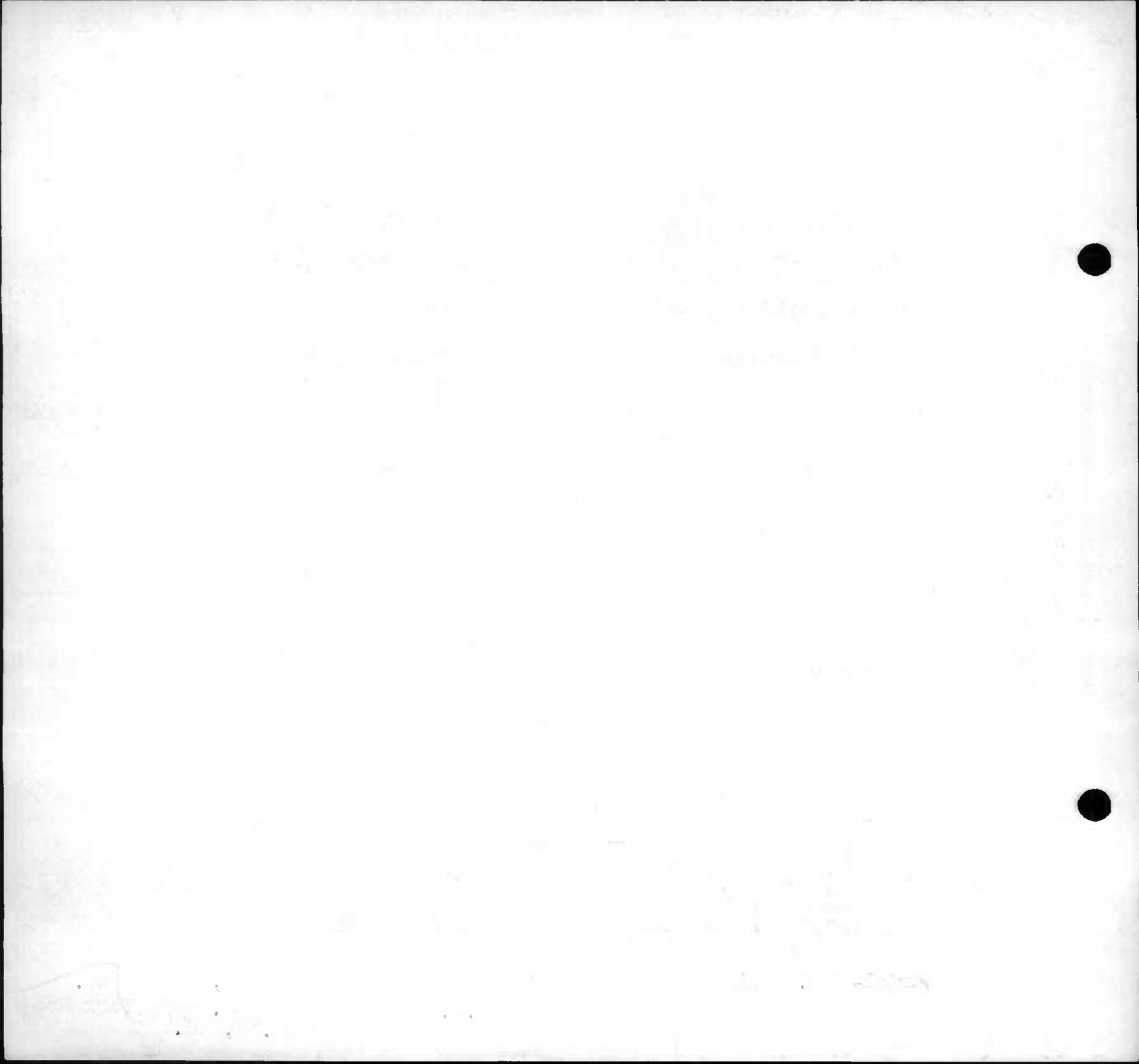
67 5980		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5980	
BIRTH NO.		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Edward P. Crummer		June 19, 1967 2:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
CERTIFICATE AMENDED 7-26-67		A. STATE Maryland			
HOSPITAL OR INSTITUTION 90 Longgreen Nursing Home		B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21218 12-01			
		D. STREET ADDRESS (If rural, give location) 302 Suffolk Road			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4/27/1877	9. AGE (In years last birthday) 90	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Lawyer		10B. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Crummer		14. MOTHER'S MAIDEN NAME Elizabeth Plaskitt	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-2488		17. INFORMANT George W. Baker, Jr. 906 Munsey Bldg. (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) <u>Bronchopneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>54 hrs.</u>		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO (B) _____ (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>A-S heart disease</u>				<u>5 yrs.</u>	
19A. DATE OF OPERATION <u>6/19</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/12</u> 19 <u>62</u> to <u>6/19</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/18</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE <u>Norman R. Freeman Jr.</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6/19/67</u>	
23C. PHYSICIAN'S NAME (Type) Norman R. Freeman Jr. M.D.		23D. ADDRESS 11 W. 29th St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/21/1967		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 21 1967			
25B. NAME OF REGISTRAR <u>R. E. E. E. E.</u>		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			

Letter from George W. Baker Jr. Attorney
7-26-67 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT.		67 5981		67 5981	
BIRTH NO.		M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
HAROLD O. LUDWIG		June 19, 1967		4 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
932-G BELGIAN AVE.		Md.			
00		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE		27-10	
D. STREET ADDRESS (If rural, give location)					
932-G BELGIAN Ave.					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
M	W	WIDOWED	June 11, 1904	63 y.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
OXYGEN THERAPIST		at HOSPITAL		NEW ORLEANS, LA.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOHN LUDWIG		MATILDA, FLEDA SIDDONS		AMER (USA)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		128-28-8112		MRS. M.E. McNAB (SISTER)	
				ADDRESS 1320 FAIRFAX QV. N. TONAWANDA N.Y.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		at least 5 mo.	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JAN 19 1967 to JUNE 19 1967 that (I) (we) last saw the deceased alive on JUNE 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
C.E. Arana				JUNE 19, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
CARLOS E. ARANAGA		M.D. 5428 Sinclair Lane Balto. 21206			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial-Rem6/22/1967				Cypress Grove	
				New Orleans, La.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 21 1967		Robert E. ...		H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5982	
BIRTH NO. 67 5982				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Julia Gedrowicz			
2. DATE AND HOUR OF DEATH		6/20/67 8:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, or institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hosp 33rd + N. Calvert		A. STATE MD B. COUNTY BALT. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4020 Deepwood Rd			
5. SEX Female	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 5/1/86	9. AGE (In years, months, days) 81	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH - PLACE (State or foreign country) Poland	
13. FATHER'S NAME Paul Chapchowski		14. MOTHER'S MAIDEN NAME ? Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. J. Kupiec Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Cerebro Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH 5 days	
19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(A) DUE TO		(B) DUE TO	
(C) DUE TO		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/11/67 to 6/20/67 that (I) (we) last saw the deceased alive on 6/20/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Robert P. Doyle		23B. DATE SIGNED 6/20/67	
23C. PHYSICIAN'S NAME (Type) DR ROBERT P DOYLE		23D. ADDRESS THE UNION MEMORIAL HOSPITAL		23E. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/23/1967		24C. NAME OF CEMETERY or CREMATORY Holy Rosary	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. ADDRESS 4905 York Rd. Balto. 12, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 21 1967	
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Rd. Balto. 12, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 5983		67 5983	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
WILLIAM H. SCOTT			6-20-67 11:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
MERCY HOSPITAL			MARYLAND 20-03		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE		
			D. STREET ADDRESS (If rural, give location)		
			2018 WILKENS AVE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
MALE	White	MARRIED	12-26-99	67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Guard		Industrial		PENNSYLVANIA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Scott T			Elizabeth Michael		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
YES 9-14-19 to 9-13-20		205-03-2773	EVALINE SCOTT 2018 WILKENS AVE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
			Hypoproteinemia 1yr.		
			Malnutrition 1yr.		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
4/26/67		Explore - Ap & Biopsy		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., home or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-3-67 19 67 to 6-20-19 67, that (I) (we) last saw the deceased alive on 6-20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
NARONG RUANGRUCHIRA M.D.				6-20-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
NARONG RUANGRUCHIRA M.D.				M.H.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-23-67		London Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 21 1967		R. E. E. E.		GEO. L. Schlab Funeral Home Address Francis & Miller 2101 Frederick Ave.	

John Scott
1850

John Scott
1850

John Scott
1850

John Scott
1850

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				67 5984		67 5984	
BIRTH NO.				67 5984		Registered No.	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Charles Jackson		2. DATE AND HOUR OF DEATH 6/14/67 9:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 20-04			
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. Maryland			
(If not in hospital or institution, give street address or location)				D. STREET ADDRESS (If rural, give location) 2538 Hollins St.			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8-5-1900	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? yes
13. FATHER'S NAME Jackson				14. MOTHER'S MAIDEN NAME J			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Dorothy Smallwood ADDRESS Hollins St 2538		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Encephalomalacia				CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 7 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bilat. confl. bronchopneumonia							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Argon Atac				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/15/67	
23C. PHYSICIAN'S NAME (Type) Argon Atac				23D. ADDRESS M.D. Bon Secours Hospital, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/20/67		24C. NAME OF CEMETERY or CREMATORY Balt National		24D. LOCATION (City, town, or county) (State) Balt City	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1967		25B. NAME OF REGISTRAR E. E. E. E.		25C. FUNERAL DIRECTOR Ed Brown		ADDRESS 10810 Montgomeys	

N-425

67 5985

BALTIMORE CITY HEALTH DEPARTMENT

5985

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (JOHNNIE) JOHNIE L. NELSON		2. DATE AND HOUR PRONOUNCED DEAD June 12, 1967 2:20 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 43 South Baltimore General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 22-01	
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 127 W. Montgomery Street	
5. SEX Male	6. RACE Negro	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH FEB 26, 1946
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 21
13. FATHER'S NAME GEORGE NELSON		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY?
		17. INFORMANT EDWARD J. NELSON	ADDRESS 1016 LEADENHALL

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E982X Stabwound of neck		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 23-01 Corner of Henretta & Leaderhall St.	
21D. TIME OF INJURY (APPROX.) 6-12-67 1:35 A.M.	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Stabbed during altercation	

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Springate** M.D. CHIEF MEDICAL EXAMINER ☐

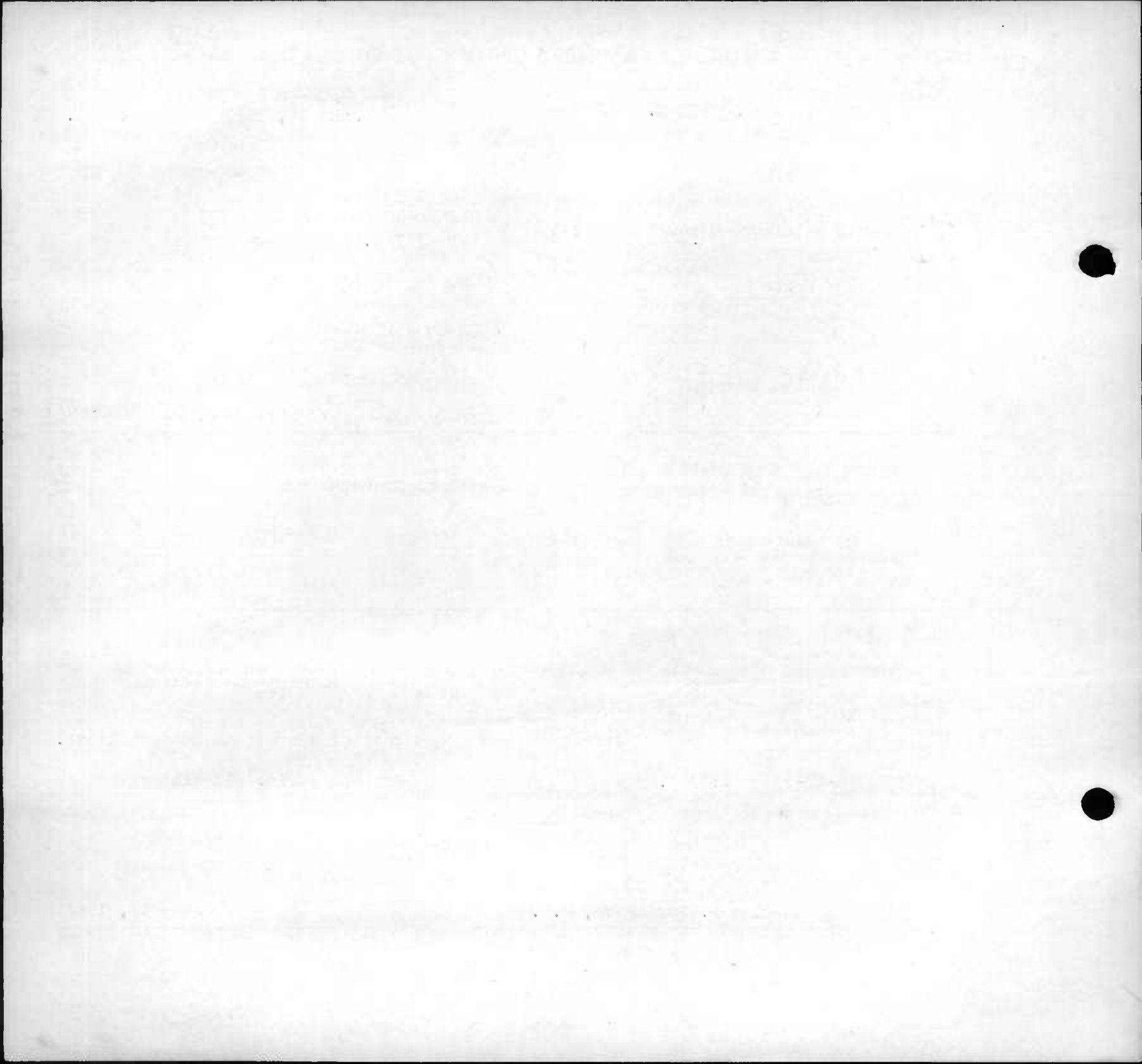
EXAMINER'S NAME (Type) **Charles S. Springate, M.D.** ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **June 12, 1967**

23A. BURIAL CREMATION, REMOVAL (Specify) Removal	23B. DATE 6/14/67	23C. NAME OF CEMETERY or CREMATORY Manning	23D. LOCATION (City, town, or county) (State) Al
24A. DATE REC'D BY HEALTH DEPT. JUN 21 1967	24B. NAME OF REGISTRAR Robert E. Barker	24C. FUNERAL DIRECTOR 108 W. Montgomery St.	ADDRESS

N 87423 67 000 5985

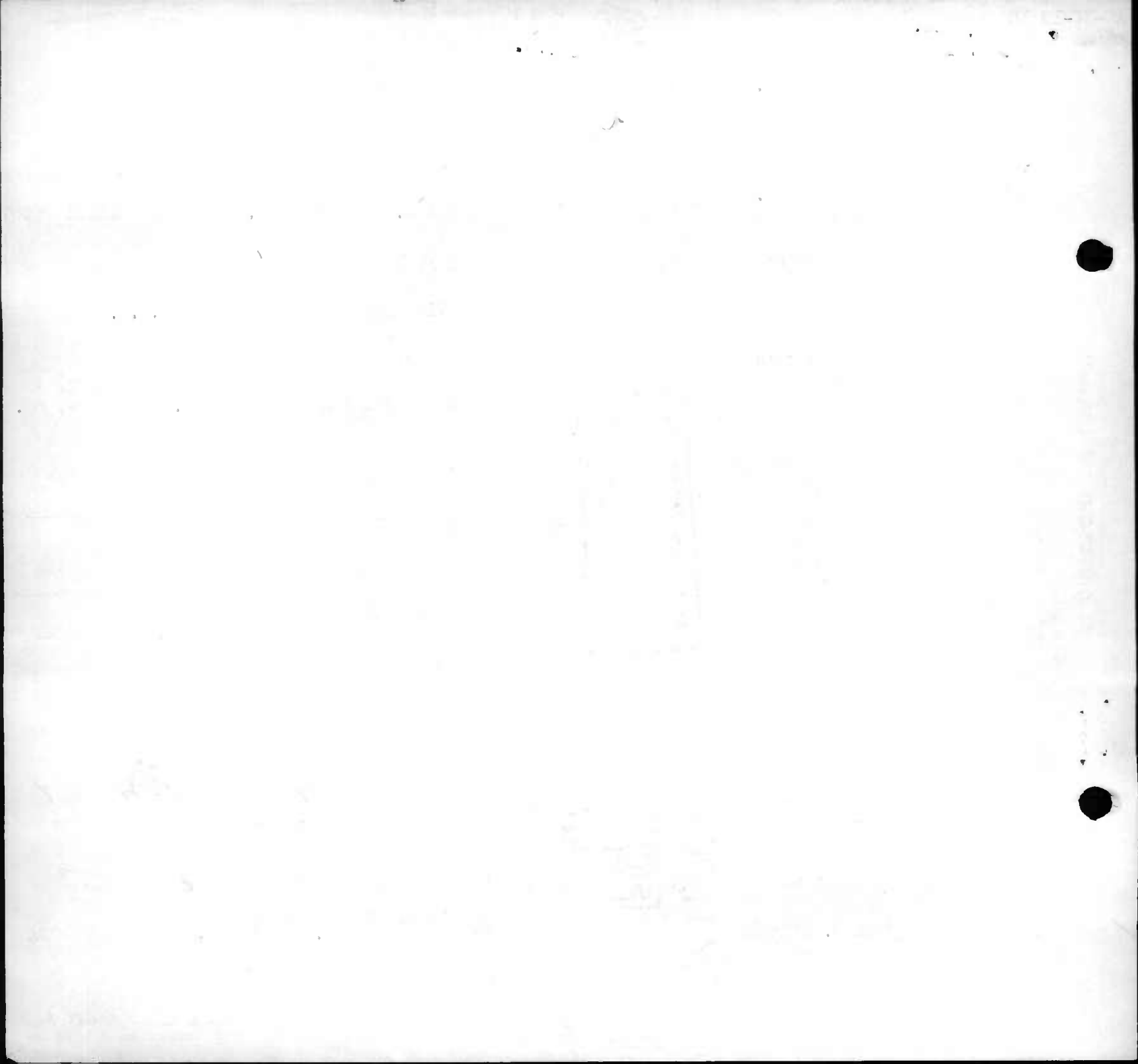


49-20-13 ED 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

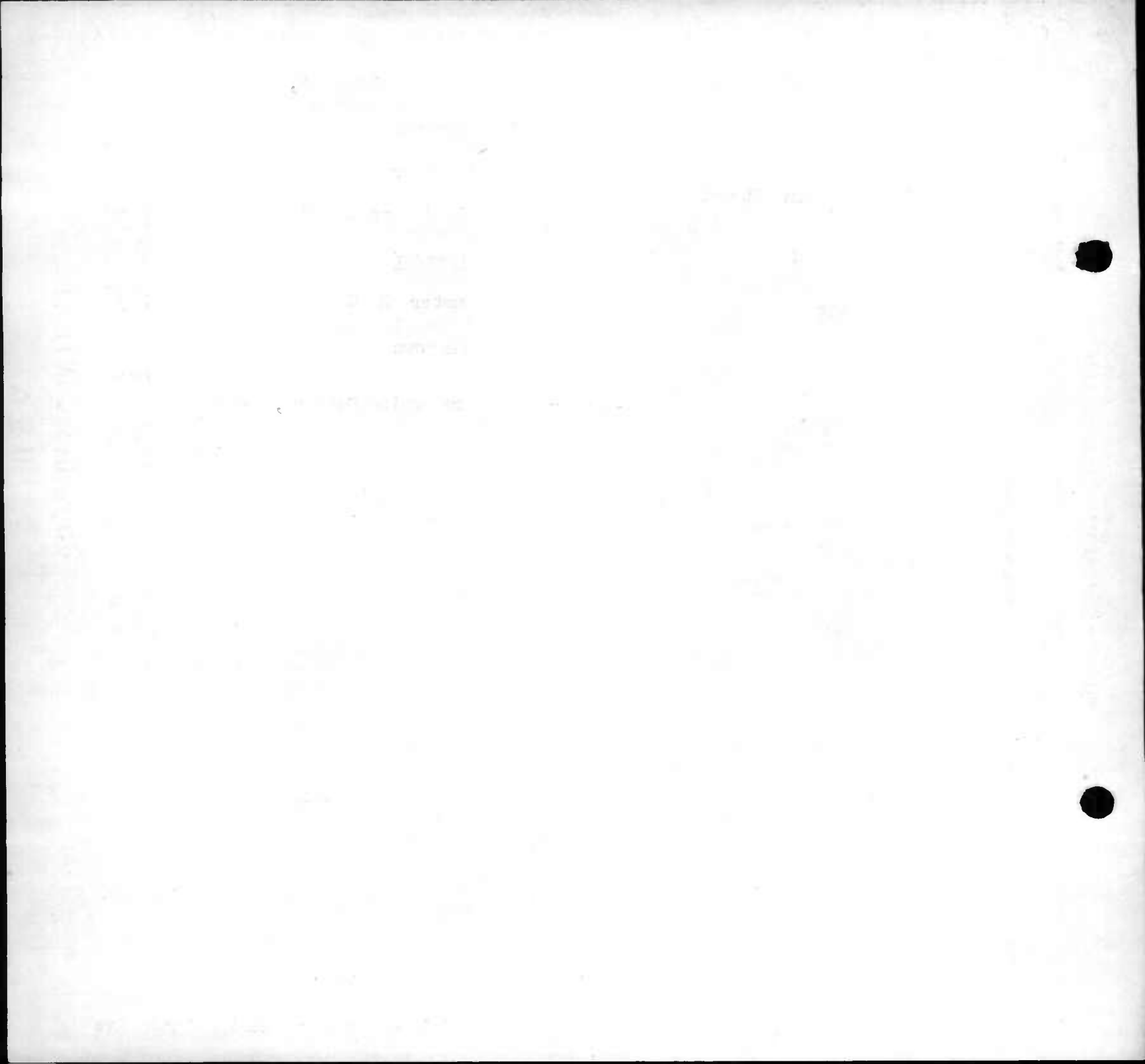
BIRTH NO. 5-420		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5986	
M.E. CASE NO.		67 5986		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Clayton B. Schools			2. DATE AND HOUR OF DEATH 6-19-67 9 PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY X		
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 221 N. Freemont Ave. Apt 1309 21201 007		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/6/16	9. AGE (In years lost birthday) 50	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Schools		14. MOTHER'S MAIDEN NAME Bertha	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 267-2-2100		17. INFORMANT BCH: Records 4940 Eastern Ave. Baltimore, Md.	
18. DISEASE OR CONDITION DIRECT LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) state the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Respiratory Arrest (B) Aspiration Gastric Contents (C) Pulmonary Tuberculosis prob. inactive		
19. DATE OF OPERATION 2			20. AUTOPSY? (Yes or No) YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 5-3 1967 to 6-19 1967, that (I) (we) last saw the deceased alive on 6-19-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce G. Whipple				23B. DATE SIGNED 6-19-67	
23C. PHYSICIAN'S NAME (Type) Bruce G. Whipple				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/23/67		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 21 1967		25B. NAME OF REGISTRAR Wm. C. March	
25C. FUNERAL DIRECTOR Wm. C. March		25D. ADDRESS 928 E. North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

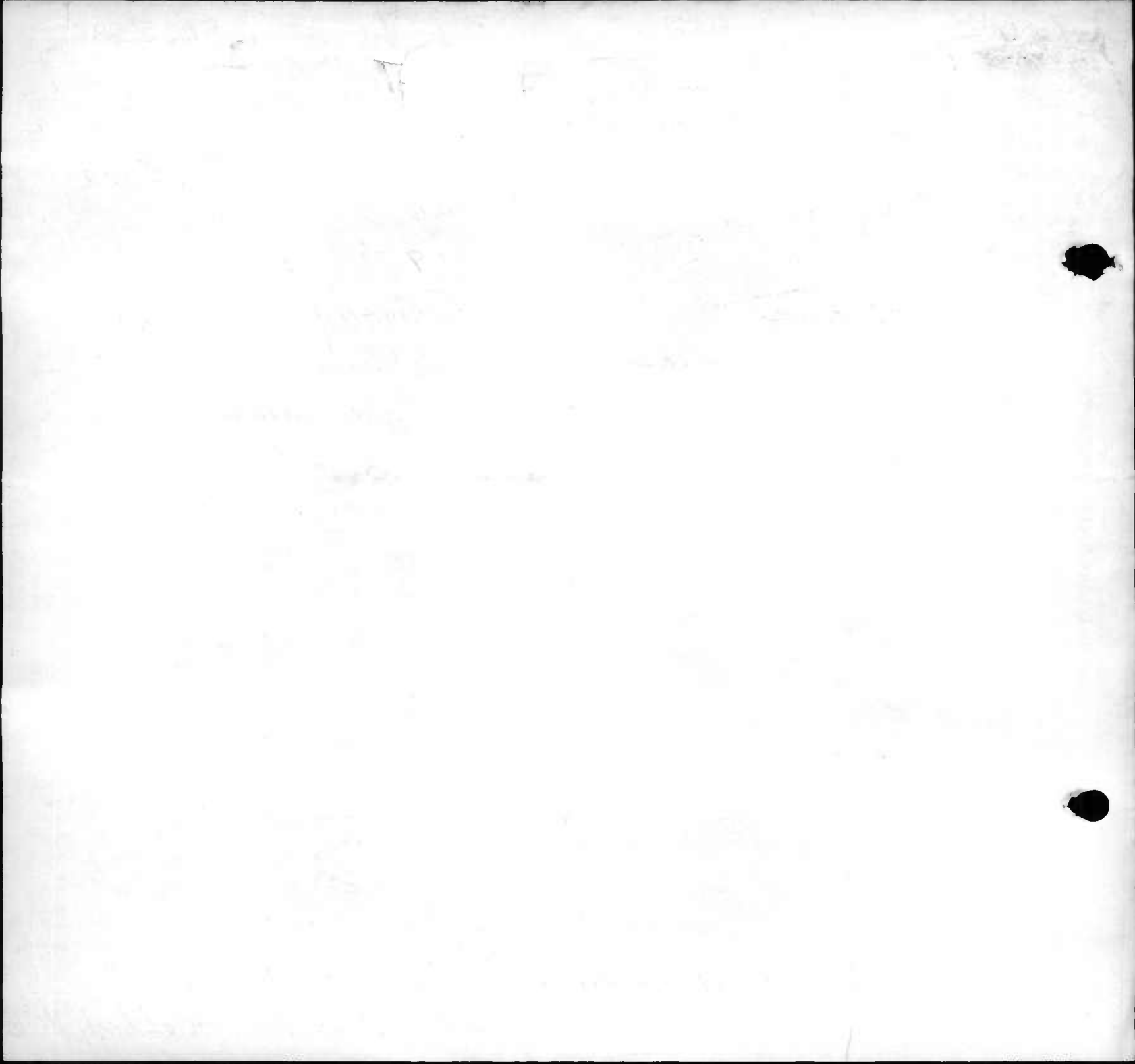
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5987	
BIRTH NO. 67 5987				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Catherine Handy				June 18, 1967 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1006 Warden Street				A. STATE Maryland B. COUNTY 10-01	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
				D. STREET ADDRESS (If rural, give location) 1006 Warden St	
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 1/25/01	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Old age			11. BIRTHPLACE (State or foreign country) Sumter S C		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 213-18-2250		17. INFORMANT Mrs Louise Butler, same
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arterio sclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 5 yrs					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Vascular accident 1 day.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1965 to 13 June 1967 , that (I) (we) last saw the deceased alive on 13 June 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. C. Burnell				23B. DATE SIGNED 6/19/67	
23C. PHYSICIAN'S NAME (Type) C. C. BURNELL				23D. ADDRESS 1924 W. North Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/23/67		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md					
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1967		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Adolphus Halstead	
ADDRESS 1206 W North Ave					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5988	
67 5988				CITY HEALTH DEPARTMENT	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Pepler Margaret	
2. DATE AND HOUR OF DEATH June 19th 1967 12.30 A. M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND Sinai Hospital of Baltimore			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY BALTO Co.		5. FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI			
6. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		7. STREET ADDRESS (If rural, give location) 3616 Oak Ave.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Wid.	8. DATE OF BIRTH 11/9/79	9. AGE (In years last birthday) 88	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY	
13. FATHER'S NAME LORZ		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NO		17. INFORMANT Louis Pepler - Same	
18. 422/1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) CVA		8 days	
ANTECEDENT CAUSES		(B) ASCVD		Un Known	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/13 19 67 to 6/19 19 67 , that (I) (we) last saw the deceased alive on 6/19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William Cieplinski				23B. DATE SIGNED 6/19/67	
23C. PHYSICIAN'S NAME (Type) William Cieplinski				23D. ADDRESS Sinai Hospital of Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-21-67		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) BALTO, Md		25A. DATE REC'D BY HEALTH DEPT. JUN 21 1967		25B. NAME OF REGISTRAR Robert E. ...	
25C. FUNERAL DIRECTOR Ellsworth Armacost		25D. ADDRESS 4600 Liberty Hgts			



1
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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 5989 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5989

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) THOMAS B. GARDNER 2. DATE AND HOUR PRONOUNCED DEAD June 19, 1967 9:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1803 Penrose Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1803 Penrose Avenue

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed 8. DATE OF BIRTH Oct. 6, 1879 9. AGE (In years lost birthday) 87 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Britton Gardner 14. MOTHER'S MAIDEN NAME Maria Willis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT George Gardner 18. CAUSE OF DEATH

18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Prostate DUE TO

(B) DUE TO

(C) DUE TO

II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK [] 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry [] Inspection [X] Autopsy [] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [] Suicide [] Homicide [] Undetermined manner []

ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER [] M.D. ASSISTANT MEDICAL EXAMINER [X] ASSOCIATE MEDICAL EXAMINER []

DATE SIGNED

6/19/67

23A. BURIAL CREMATION, REMOVAL (Specify) 23B. DATE 23C. NAME OF CEMETERY or CREMATORY 23D. LOCATION (City, town, or county) (State)

Removal 6/20/67 Union Zion Gloucester U.A.

24A. DATE REC'D BY HEALTH/DEPT. 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR ADDRESS

JUN 21 1967

Wilson Oct. 5, 1874
Petit
Benton Jackson
Maine Maine
Hampden Hampden

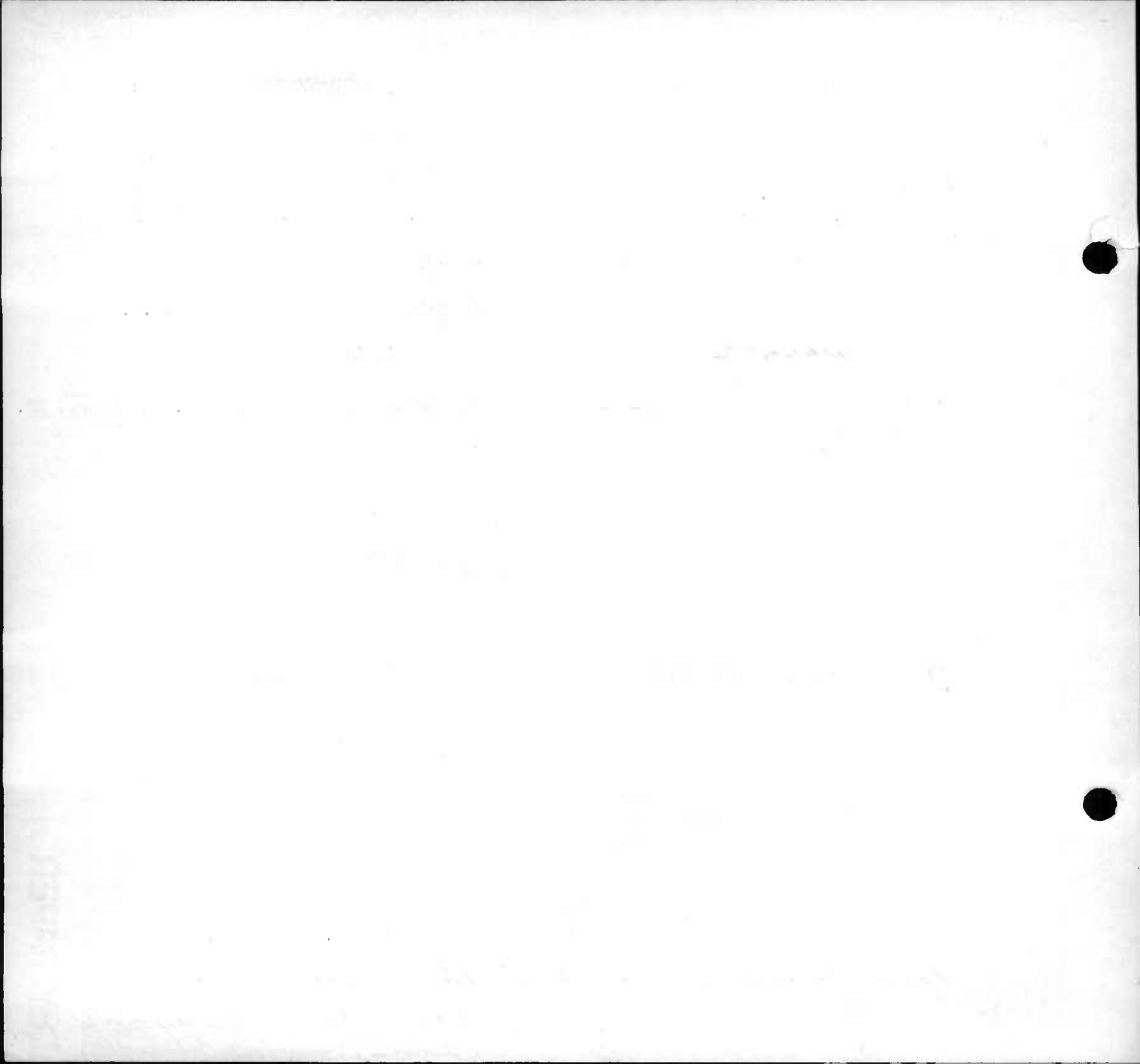
1874

General of the 1st Maine
Maine

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5990		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 5990	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WALKER, RICHARD		2. DATE AND HOUR OF DEATH 6/20/67 7:20 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224		D. STREET ADDRESS (If rural, give location) 2801 E. Preston St. 21213 007		8-03	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6-20-05	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Sam WALKER		14. MOTHER'S MAIDEN NAME Lizzie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 223-48-7794		17. INFORMANT BCH: Records 4940 Eastern Ave. Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 163X I Legs pneumonia		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) (2) upper lobe malignant tumor		INTERVAL BETWEEN ONSET AND DEATH 4 days. 1 week. ? 3 months.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6/13/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED malignant tumor RUL		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 5/24/67 to 6/20/67 and that (I) (we) last saw the deceased alive on 6/20/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Salvo Singh		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/20/67	
23C. PHYSICIAN'S NAME (Type) PABLO TREFOLLI		M.D. 23D. ADDRESS 4940 Eastern Ave. Baltimore, Maryland #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6/21/67		24C. NAME of CEMETERY or CREMATORY Harvill's Place	
24D. LOCATION (City, town, or county) (State) CARSON-VA		25A. DATE RECEIVED BY HEALTH DEPT. JUN 21 1967		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR Maybelle Baffins 638 N. Green St		ADDRESS Blair Funeral Home Petersburg VA			



15-140

67 5991 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5991

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ANTHONY

SOPEL

2. DATE AND HOUR PRONOUNCED DEAD

June 20, 1967

8:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

35 CHURCH HOME AND HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

122 N. Collington Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

6/13/1907

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cab Driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Peter Sopol

14. MOTHER'S MAIDEN NAME

Lucy Jablonski

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

212-16-6126

17. INFORMANT

ADDRESS

Mrs. Elizabeth D. Sopol 122 N. Collington Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, embolism, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/20/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/24/67

23C. NAME OF CEMETERY or CREMATORY

Inc. Lake View Memorial Park, Baltimore, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 21 1967

24B. NAME OF REGISTRAR

Robert E. Fink

24C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Baltimore St

ADDRESS

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

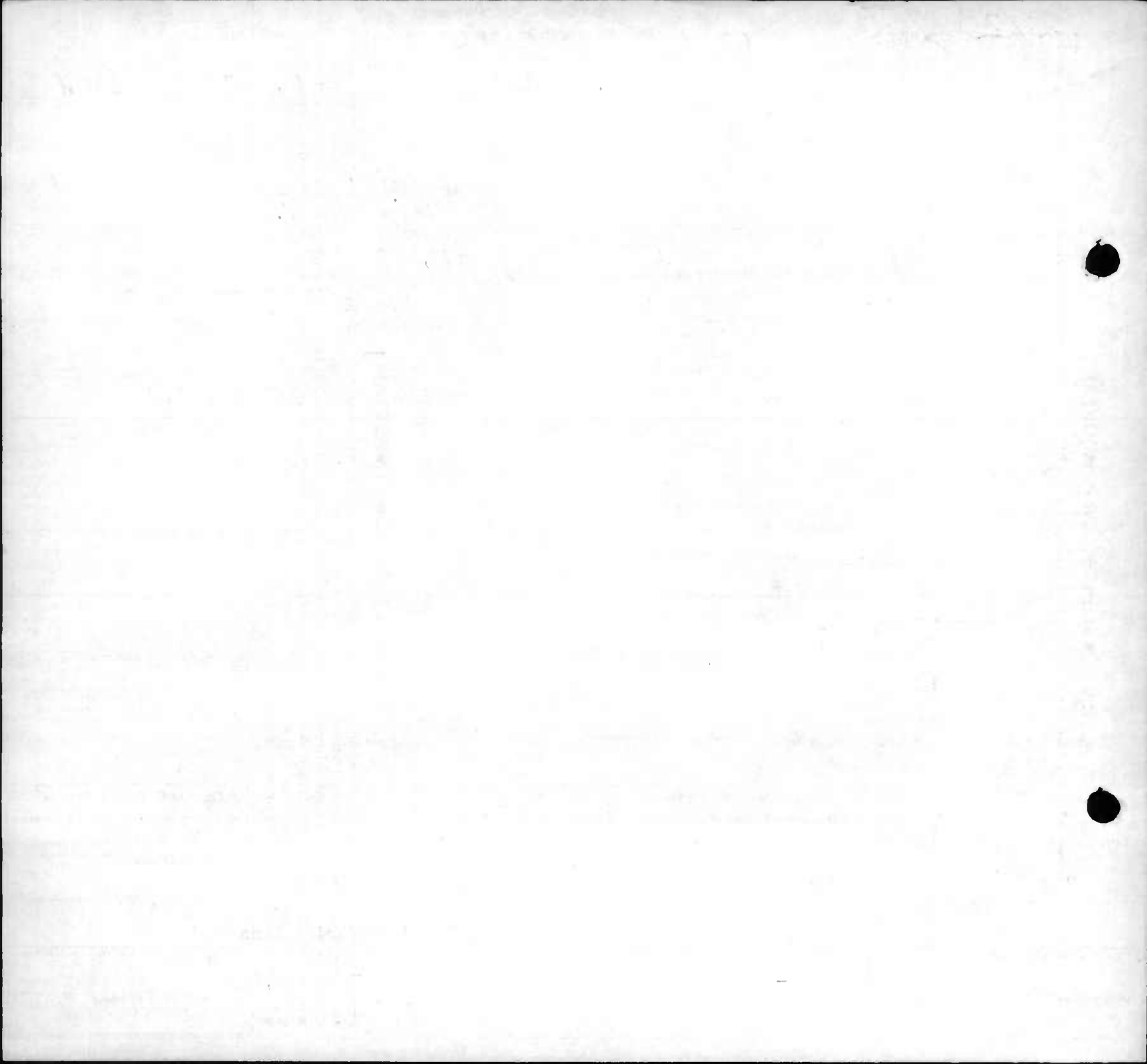
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100-100-100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

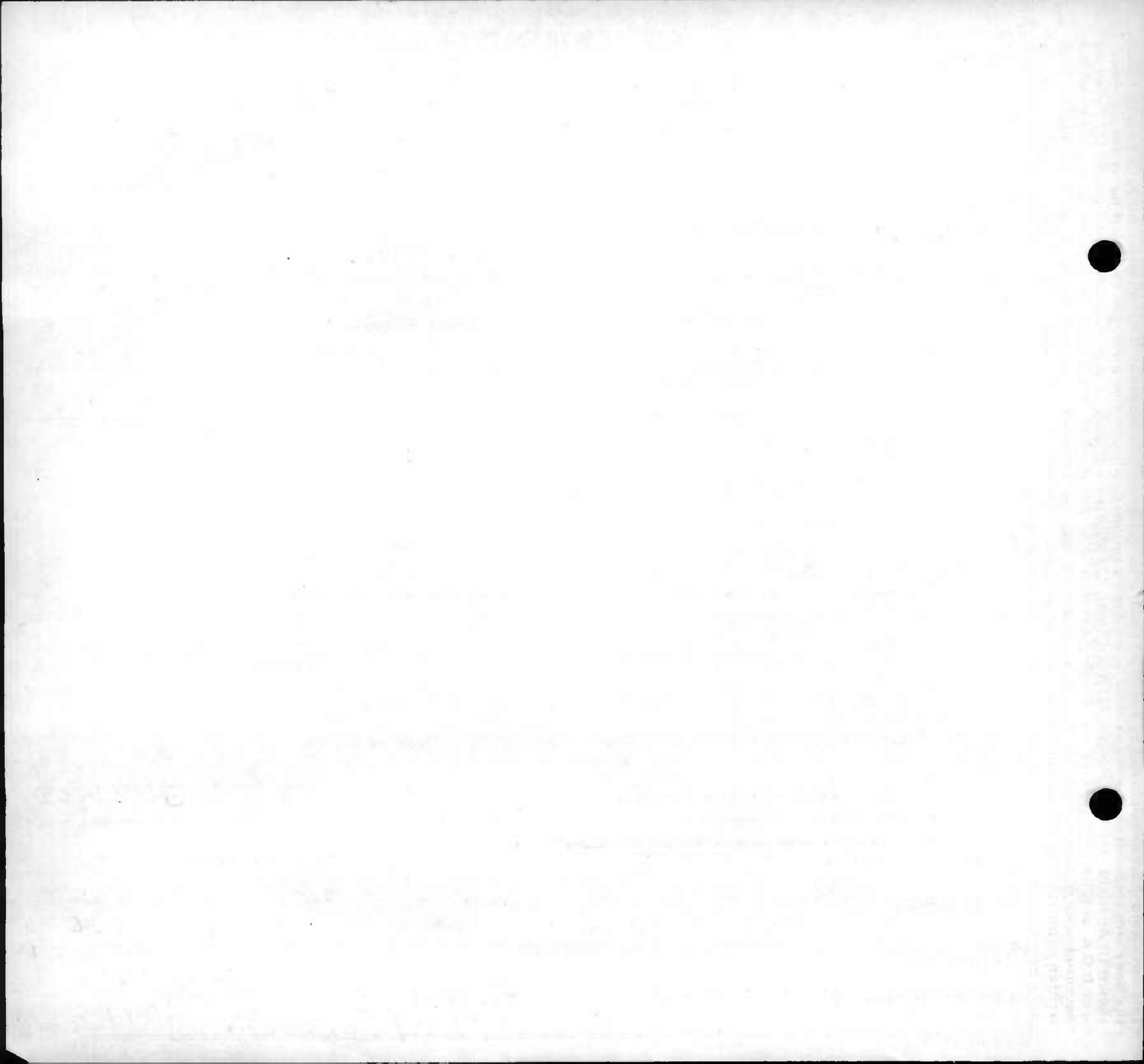
BALTIMORE CITY HEALTH DEPARTMENT											
67 5992 CERTIFICATE OF DEATH					Registered No. 67 5992						
BIRTH NO.											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH						
Alexander T. Yanusis					June 18, 1967 5:50 A M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4818 Coleherne Road 00					A. STATE Maryland						
					B. COUNTY						
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)						
					Baltimore						
					D. STREET ADDRESS (If rural, give location)						
					4818 Coleherne Rd. 28-04						
5. SEX Male	6. RACE Wh	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH May 10, 1885	9. AGE (In years last birthday) 82	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		11. BIRTHPLACE (State or foreign country) Lithuania			
						12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Yanusis					14. MOTHER'S MAIDEN NAME —						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no no					16. SOCIAL SECURITY NO. 216 07 0561		17. INFORMANT Mrs Mildred Sutt			ADDRESS 707 Stamford Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 1. LUNG CANCER 2. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Lung Cancer DUE TO (B) DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 1960 to June 18, 1967, that (I) (we) lost saw the deceased alive on June 18, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Stanley Ankudas					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 6/20/67			
23C. PHYSICIAN'S NAME (Type) Stanley Ankudas					23D. ADDRESS M.D. 1101 Maiden Choice Lane #21229						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-22-67		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery Mausoleum			24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland				
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1967			25B. NAME OF REGISTRAR Robert E. Tinkler			25C. FUNERAL DIRECTOR Thomas J. Kerry Inc			ADDRESS 1600 Hollins St		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 5993		CERTIFICATE OF DEATH		67 5993	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM L. POWELL		2. DATE AND HOUR OF DEATH JUNE 16, 1967 430 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 3300 WEEDON AVE FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALT. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT., MD. D. STREET ADDRESS (If rural, give location) 25-06			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JAN. 30, 1880	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME FRED POWELL		14. MOTHER'S MAIDEN NAME MIRINDA		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-01-5333		17. INFORMANT FAMILY ADDRESS	
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) MYOCARDIAL INFARCTION (B) ARTERIO SCLEROTIC C-V DIS. (C)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/14/1967 to 6/16/1967 , that (I) (we) last saw the deceased alive on 6/10/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.					
23A. SIGNATURE John S. Braxton Jr. M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 6/20/67	
23C. PHYSICIAN'S NAME (Type) JOHN S. BRAXTON JR. M.D.				23D. ADDRESS 922 S. SHARP ST. - BALT. 30 MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial June 20/67		June 20/67		Quibb's Memorial	
25A. DATE RECEIVED BY HEALTH DEPT. JUN 21 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Robert Williams ADDRESS 1941 N Bond St	



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

CHARLES CALLAHAN

2. DATE AND HOUR PRONOUNCED DEAD

6-10-67

11:40 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

201 E. NORTH AVENUE - Amb. Crew #3

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

201 E. North Avenue - Room #10

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty infiltration of liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Chronic alcoholism
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-11-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

JUN 12 1967

23C. NAME OF CEMETERY

ANATOMY BOARD OF MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

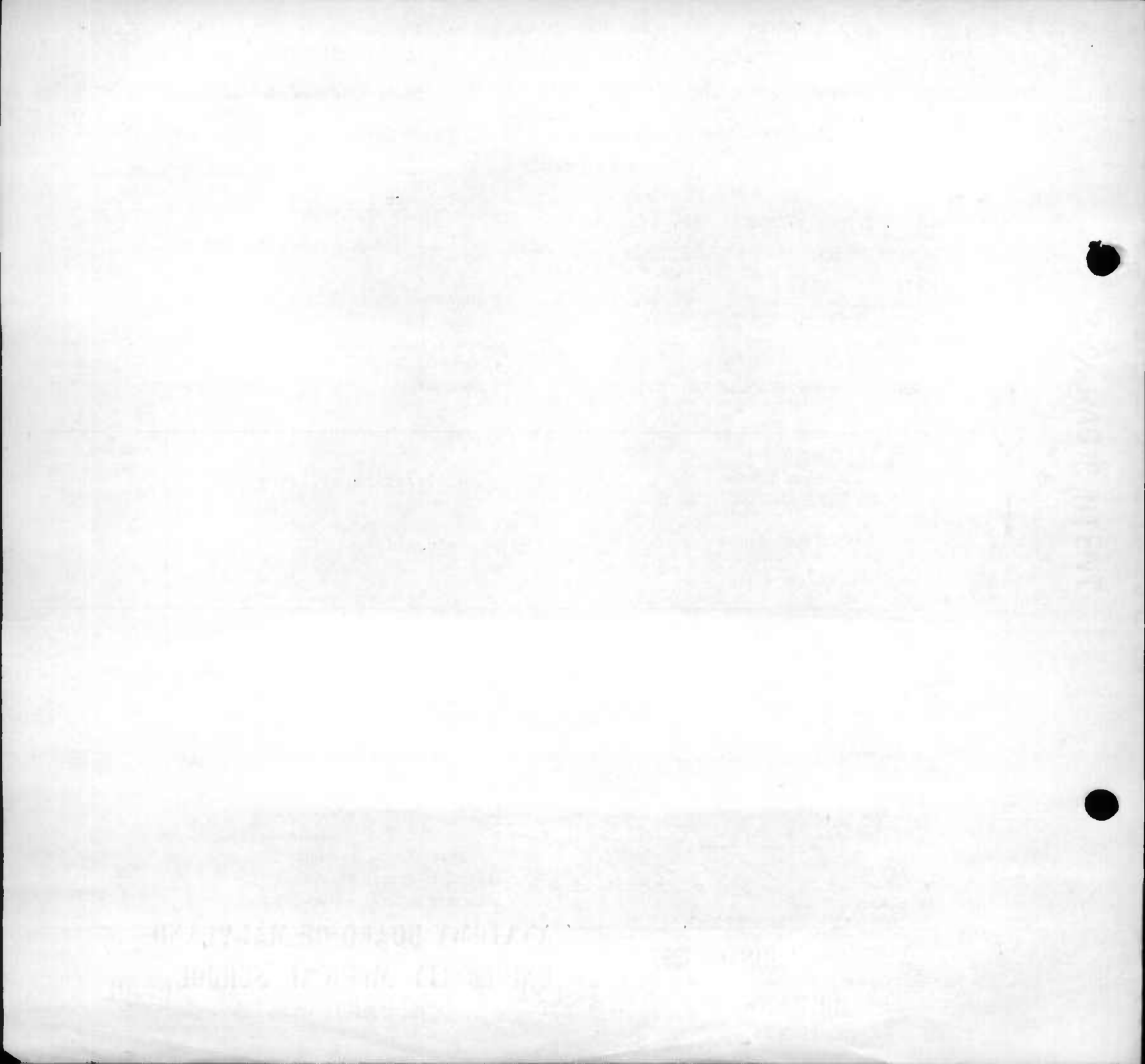
JUN 21 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD



E. 470

67 5995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 5995

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MRS DOROTHY ELLIS

2. DATE AND HOUR OF DEATH

6-17-67 12:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD. BALTIMORE 27-09

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1511 PENTRIDGE RD. 1511

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.

F

W

WIDOWED

2-4-07

60

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

HOUSEWIFE

HOUSEWIFE

BALTIMORE, MD.

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

ARTHUR PORTER

HELEN ANDREWS

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

UNKNOWN

214-03-6683

PATIENT

18. 581.01

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) BLEEDING GASTRIC ULCER YEARS
DUE TO

ANTECEDENT CAUSES

(B) MARKED NUTRITIONAL CIRRHOSIS YEARS
DUE TODISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

6-16-67

BLEEDING ULCER

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work ☐ Not While
At Work ☐22. I certify that (I) (this hospital) attended the deceased from June 10, 1967 to June 17, 1967.
that (I) (we) last saw the deceased alive on June 17, 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Charles S. Harrison

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6-17-67

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

M.D.

MARYLAND GENERAL HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY

CREMATORY

24D. LOCATION

(City, town, or county)

(State)

JUN 20 1967

ANATOMY BOARD OF MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. HOSPITAL OR

ADDRESS

JUN 21 1967

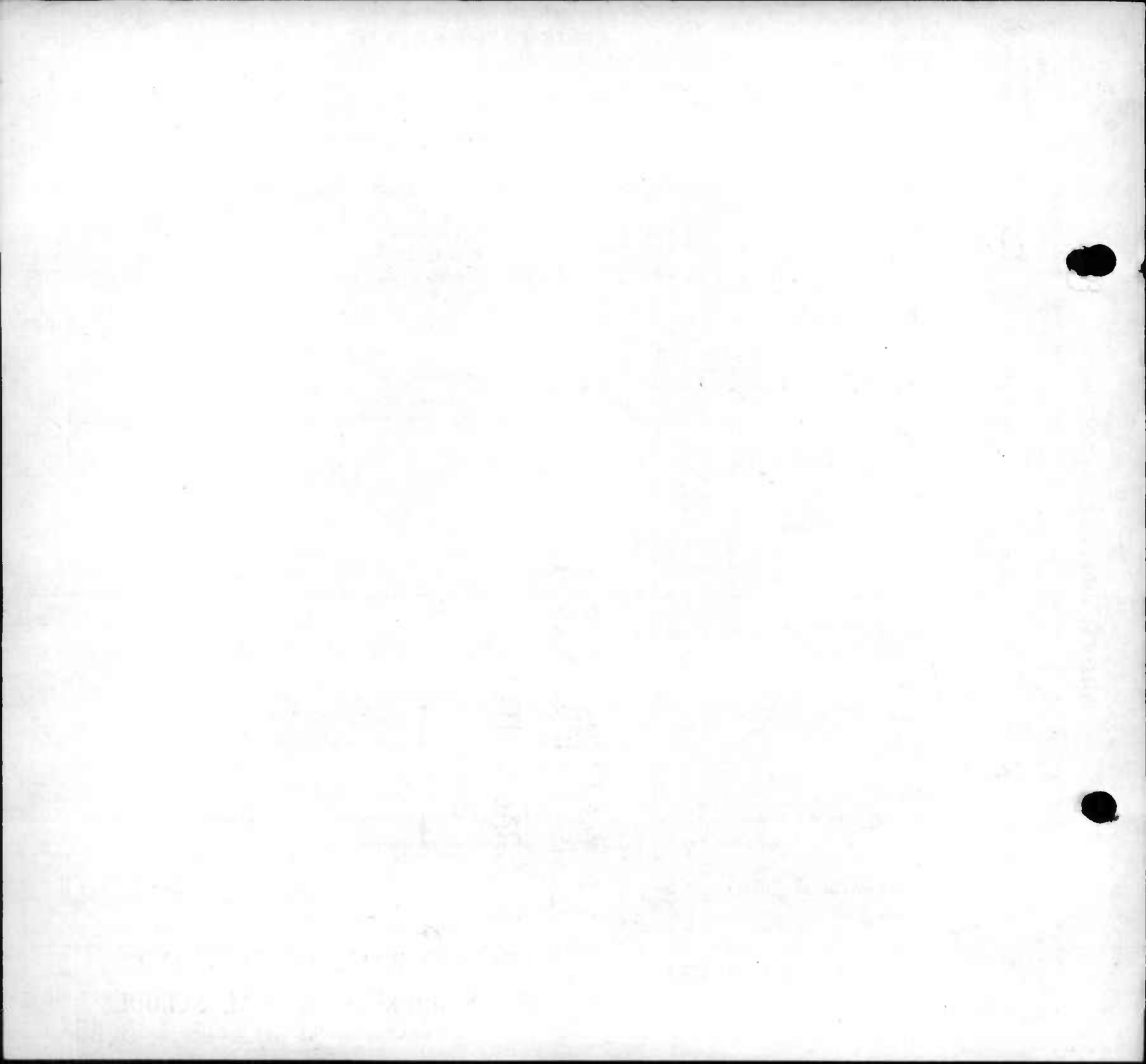
Robert E. Harrison

JOHNS HOPKINS MEDICAL SCHOOL

MORTUARY SERVICE - BCHD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-460

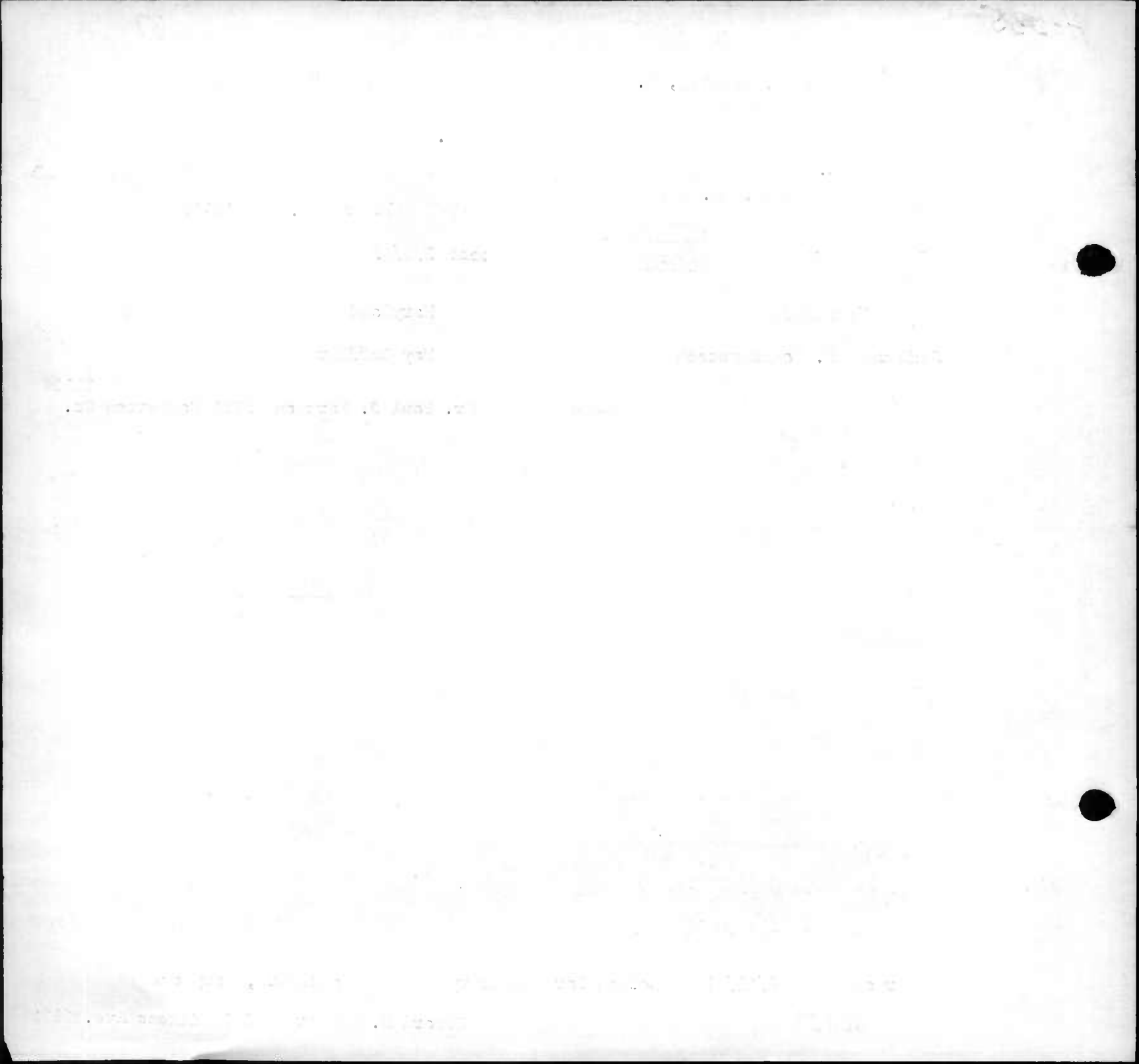
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 5986		CERTIFICATE OF DEATH		Registered No. 67 5986	
1. NAME OF DECEASED (Type or Print) TAYLOR IDELLE W.				2. DATE AND HOUR OF DEATH 6/18/67 10:30 A M M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSPITAL 34				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #29 16-08 D. STREET ADDRESS (If rural, give location) 607 N. WOODINGTON Rd					
5. SEX F	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 7-4-94	9. AGE (In years last birthday) 72	11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY RETIRED						
13. FATHER'S NAME MEREAN, WHEELER				14. MOTHER'S MAIDEN NAME EMILY O'CONNER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 217-05 4432 D.		17. INFORMANT Edward G. Taylor, Sr. Jr.				ADDRESS 21043
18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) INTERSTITIAL OBSTRUCTION			CAUSE OF DEATH (A) DUE TO INTERSTITIAL OBSTRUCTION			INTERVAL BETWEEN ONSET AND DEATH 3 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			(B) DUE TO Cardiac Failure			12 hrs			
(C) DUE TO Arteriosclerosis									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 6/16			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from 6-10 19 67 to 6-18 19 67 , that he (we) last saw the deceased alive on 6-18 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) not view the body after death.									
23A. SIGNATURE Milagros L. Guerrero M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-18-67	
23C. PHYSICIAN'S NAME (Type) MILAGROS L. GUERRERO M.D.						23D. ADDRESS BON SECOURS HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 6/21/67			24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1967			25B. NAME OF REGISTRAR Howard H. Hubbard			25C. FUNERAL DIRECTOR Hubbard's			ADDRESS 4107 Wilkens Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

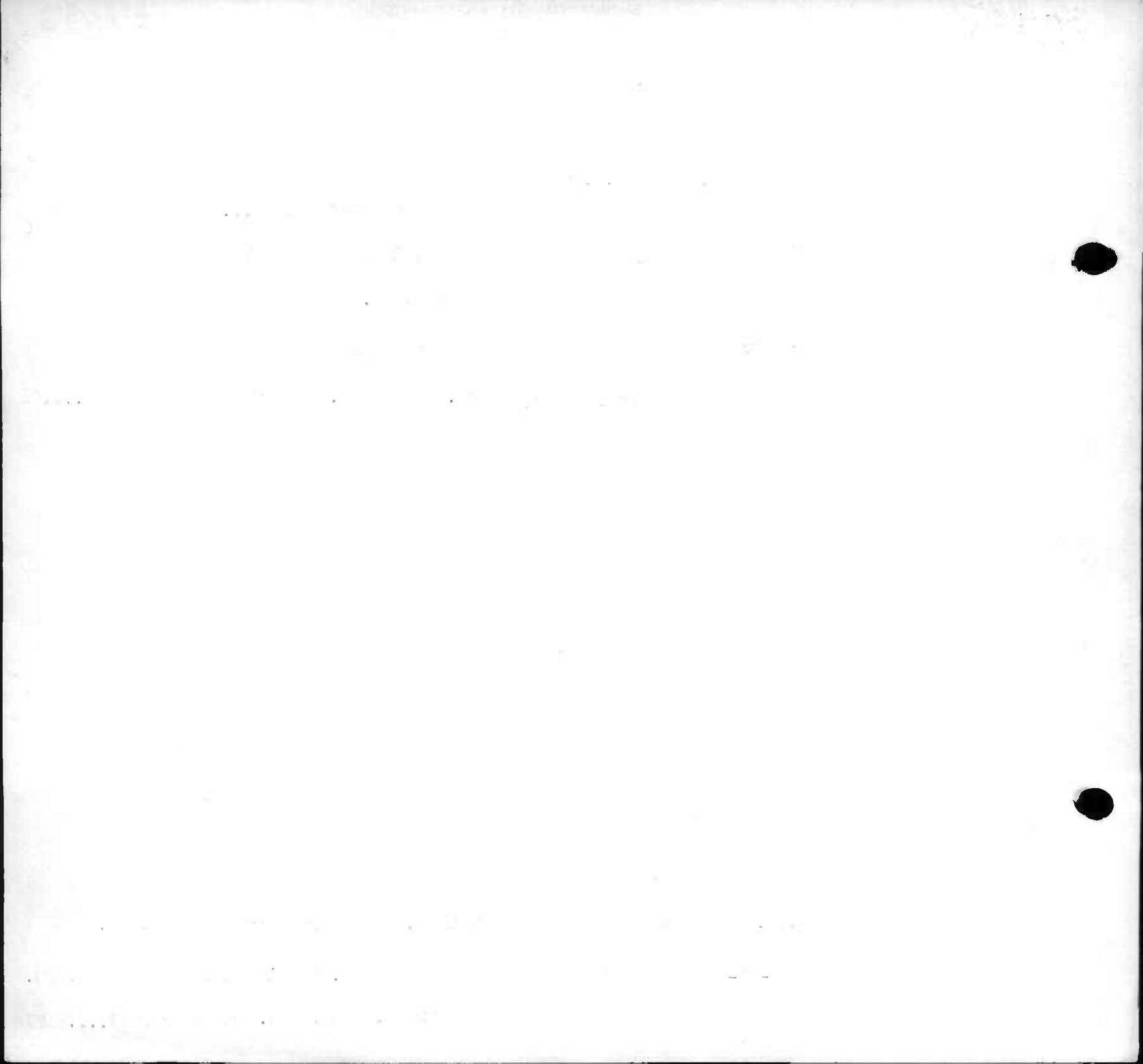
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 5997	
BIRTH NO. 67 5997											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) Hartman, Estella, M.						2. DATE AND HOUR OF DEATH 6/18/67 12 Noon					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital Baltimore, Md. 21229						A. STATE Md.					
						B. COUNTY					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
						D. STREET ADDRESS (If rural, give location) 2727 Wilkens Ave. 21223					
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 3/1/95		9. AGE (In years last birthday) 72		10. Under 1 Yr. Months Days 10. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10B. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) Maryland						12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Jefferson D. Wannewetsch						14. MOTHER'S MAIDEN NAME May Leffler					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No						16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Paul J. Hartman 5732 Calverton St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ventricular Fibrillation 2 hrs.						INTERVAL BETWEEN ONSET AND DEATH Arteriosclerotic cardiovascular disease 7 yrs					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 18 1967 to June 18 1967, that (I) (we) last saw the deceased alive on June 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE J. KUDIRKA								M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6.18.67	
23C. PHYSICIAN'S NAME (Type) J. KUDIRKA								23D. ADDRESS 2151 Wilkens Ave. Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 6/21/67		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1967				25B. NAME OF REGISTRAR R. E. F. F.				25C. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 5998		67 5998	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		PEARL N. KYLE		June 20, 1967 2 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
00 4714 Hampnett Avenue...14		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		27-02	
		D. STREET ADDRESS (If rural, give location) 4714 Hampnett Avenue...14			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH July 4, 1889	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Luray, Va.	
13. FATHER'S NAME James Crim		14. MOTHER'S MAIDEN NAME Rosey Grim		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-52-0238		17. INFORMANT Mrs. Roberta E. Hoffman, 4519 Marx Ave....06	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Anterograde C.V.D. (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1951 to June 20 1967, that (I) (we) lost saw the deceased alive on May 22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. J. Henry Haase		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/20/67	
23C. PHYSICIAN'S NAME (Type) Dr. J. Henry Haase		23D. ADDRESS 2926 E. Cold Spring Lane, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 6-23-67		24C. NAME OF CEMETERY or CREMATORY Glen Haven	
		24D. LOCATION (City, town, or county) (State) Gov. Ritchie Hgy, Glen Burnie, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc, Baltimore, Md....21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 5999

BIRTH NO. 67 5999		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) OLA O. MEADE		2. DATE AND HOUR OF DEATH 6-19-67 1 6 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1645 WOODBOURNE BL AVE	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12-26-79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) xxx 87
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LEMUEL ORME		14. MOTHER'S MAIDEN NAME Mary E. Scrivnor	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT DOROTHY WILLIS
18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO Cardiogenic shock (B) DUE TO old Myocardial infarction (C) DUE TO ASCVD Cardiac arrest		INTERVAL BETWEEN ONSET AND DEATH 10 hours Unknown Unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-10 19 67 to 6-19 19 67, that (I) (we) last saw the deceased alive on 6-19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Timothy K. Gray M.D.		23B. DATE SIGNED 6-19-67	
23C. PHYSICIAN'S NAME (Type) TIMOTHY K. GRAY M.D.		23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/22/67.	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1967		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc. Balto. Md. 21214	
25C. FUNERAL DIRECTOR		ADDRESS	

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BIRTH NO. **67 6000** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 6000**

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) STEPHEN T. Kendryna Sr.			2. DATE AND HOUR PRONOUNCED DEAD June 20, 1967 10:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5010 Greenhill Avenue			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 26-02 D. STREET ADDRESS (If rural, give location) 5010 Greenhill Avenue		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 11, 1904	9. AGE (In years last birthday) 62	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Tailor		10B. KIND OF BUSINESS OR INDUSTRY Garment	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Stephen Kendryna			14. MOTHER'S MAIDEN NAME Marie Polek		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; if yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-01-2222	17. INFORMANT ADDRESS Mrs. Bertha Kendryna same		
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 6/20/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/20/67 ACTUAL SIGNATURE Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 6/23/67	23C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	23D. LOCATION (City, town, or county) (State) Balto. Md.		
24A. DATE REC'D BY HEALTH DEPT. JUN 22 1967		24B. NAME OF REGISTRAR Robert E. [Signature]	24C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md.		

